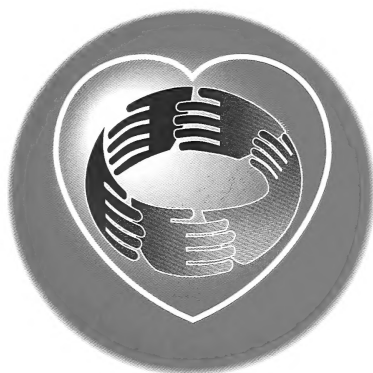


CSAP

Cultural Competence Series



The Challenge of Participatory Research:

Preventing Alcohol-Related Problems in Ethnic Communities

**Special Collaborative NIAAA/CSAP Monograph
Based on an NIAAA Conference, May 18–19, 1992**

SAMHSA



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

3

CSAP Cultural Competence Series 3

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Office of Minority Health
Resource Center

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The primary objective of the Center for Substance Abuse Prevention (CSAP) Cultural Competence Series is to promote the development and dissemination of a scientific knowledge base that assists prevention program evaluators, researchers, and practitioners in working with multicultural communities.

CSAP supports the rigorous scientific analysis of programs designed to promote health and prevent alcohol, tobacco and other drug (ATOD) problems for all people. All positions taken on specific approaches to conducting research and evaluation on ATOD problem prevention programs are positions of the researchers, communities, prevention experts, and authors who contributed to this monograph and may not necessarily reflect the opinions, official policy, or position of CSAP; the Substance Abuse and Mental Health Services Administration; the Public Health Service; or the U.S. Department of Health and Human Services. Other groups that developed and/or implemented specific methods for researching or evaluating ATOD abuse prevention programs are documented in the text of this monograph.

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This compelling volume offers both theoretical and practical applications related to the field of alcohol prevention research and its responsiveness to the pressing concerns of this country's diverse ethnic and racial communities. Underlying each of the chapters is the premise that good behavioral science recognizes the importance of cultural competence as a significant factor in the quality of data collected.

CSAP's Cultural Competence Series has as its primary goal the scientific advancement of evaluation methodology designed specifically for alcohol, tobacco, and other drug abuse (ATOD) problem prevention approaches within the multicultural context of United States community settings. The various multicultural communities which make up our country comprise a rich and diverse ethnic heritage. The Cultural Competence Series is dedicated to exploring and understanding this heritage and its critically important role in the development of ATOD problem prevention programs.

The Cultural Competence Series provides CSAP with a unique opportunity to formulate effective strategies that will have applicability for ATOD prevention professionals working in widely diverse settings. This unprecedented Series has established a framework for the transfer of innovative, cutting-edge technology in this area and a forum for the exchange of knowledge between program developers, implementors, and evaluators. It is the sincere hope of those who have contributed to this Series that it will stimulate new ideas and further prevention efforts among all Americans.

Elaine M. Johnson, Ph.D., Director
Center for Substance Abuse Prevention

For Loran Archer
Colleague, Researcher, former Administrator, NIAAA

Foreword

This volume is the third in a series of publications on cultural competence sponsored by the Division of Community Prevention and Training of the Center for Substance Abuse Prevention (CSAP). It includes the proceedings of a working group, "Alcohol Abuse Prevention Research in Ethnic Communities," held in Washington, D.C., May 18-19, 1992, sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). NIAAA and CSAP share the mission of encouraging the advancement of knowledge in the prevention of alcohol-related problems and have worked collaboratively toward this goal. For example, in 1990, a Request for Applications (RFA) was issued on "Community-Based Research on the Prevention of Alcohol-Related Problems" which resulted in the joint funding by NIAAA and CSAP of two community grants. This jointly produced monograph represents another form of collaboration between research and service agencies that facilitates communication between prevention researchers, service professionals, and others dedicated to prevention.

Throughout the volume, the concepts of participatory research, cultural competence, cultural sensitivity, and community provide the anchors for the discussion of the prevention of alcohol-related problems in ethnic/racial communities. An underlying premise of this volume is that prevention research must be based upon a clear understanding of the cultural factors that influence the processes of prevention research and the development of community prevention interventions. This understanding can be developed more effectively through collaboration between the community and researchers.

A review of the state of the art of community alcohol prevention research shows that we have much to learn about effective interventions and protective mechanisms against alcohol-related problems in ethnic/racial communities. It is likely that the state of the art will change little unless new alliances are built between academic researchers and the community, and unless these alliances encourage participation by both groups in the various stages of the research process. As is true for this CSAP Series as a whole, this volume is dedicated to furthering that effort.

*Phyllis A. Langton
Leonard G. Epstein*

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Preface

This monograph resulted from a working group held in Washington, D.C., in May 1992. One purpose of the working group was to bring together members of ethnic/racial communities and research scientists to facilitate collaboration between the two groups. The four ethnic/racial communities included: (1) American Indians and Alaska Natives, (2) Hispanics, (3) African Americans and Black Americans, and (4) Asian Americans and Pacific Islanders.

A main interest of the working group was to learn how ethnic/racial communities view alcohol use and abuse in their communities. We argue that research scientists need to include members of the ethnic/racial communities in various stages of the research process. The prevention of alcohol-related problems in ethnic/racial communities can be enhanced by inviting the community to participate in shaping the research agenda.

Other issues addressed during the working group were: (1) the need to develop greater sensitivity among researchers to the special prevention needs of ethnic/racial communities, (2) the means to develop trust between research scientists and ethnic/racial communities so that collaboration can occur, and (3) the process for converting research findings into useable tools for these ethnic/racial communities. The dialogue that developed during the working group was at times conflictual, spirited, and informative, and was productive.

Many people contributed to the successful outcome of the working group and the production of this monograph. The most important are the attendees at the working group and the authors of these papers. Nancy Colladay arranged the facilities and resources necessary for a successful working group. Elsie G. Taylor and I served as co-project officers for this project during my Intergovernmental Personnel Act (IPA) appointment at NIAAA during 1991–1992. We also co-authored the introductory paper. Amy Shapiro, Branch Secretary, was always available to provide assistance throughout the project. My colleagues, Drs. Susan Martin, Michael Hilton, and Gayle Boyd provided support

during the planning and implementation of the working group. The Prevention Branch Chief, Jan Howard, provided us with valuable guidance and the necessary resources to complete this project. In addition, she brought together the final thoughts for the research agenda, which are found in the last paper in this monograph. Len Epstein, Managing Editor, arranged for the joint collaboration of this monograph. Finally, special thanks goes to Loran Archer, former Deputy Director, NIAAA, who reviewed the entire manuscript in draft form.

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Part I

Introduction and Overview

Applying a Participatory Research Model to Alcohol Prevention Research in Ethnic Communities

Phyllis A. Langton and Elsie G. Taylor

Introduction

The prevention of alcohol-related problems in ethnic communities is an area where the interests of research scientists, service professionals, community strategists, and policy makers intersect. Yet, there has been limited community-based research on the prevention of alcohol-related problems in ethnic communities. Alcohol prevention research has been dominated by surveys of individuals in which some ethnic groups have been unevenly represented in the population samples or in the analysis (Ja and Aoki, 1993; Moskowitz, 1989). While national surveys have found disproportionately high levels of alcohol consumption among some ethnic groups, some of these surveys have been criticized for producing unreliable, invalid data on ethnic groups and for failing to provide contextual information.

Some research scientists are conceptualizing the study of alcohol-related problems using a public health model. This model contains three elements: (1) the agent—alcohol beverages or ethanol itself, (2) the individual—host, and (3) the environment—the physical, interpersonal, or social milieu surrounding

the use of alcohol. Using this model, research scientists study interactions among the three elements. The unit of analysis shifts from the individual to the community.

Using the public health model to the prevention of alcohol-related problems in ethnic communities follows a growing tradition in other fields of health and illness research. For example, the effectiveness of this approach has been shown in the area of cardiovascular disease (see Farquhar et al., 1985). There have been reductions and modification of smoking habits, eating habits, and even the control of high blood pressure that have followed from the application of this model to the community.

The public health model was central to the working group that the National Institute on Alcohol Abuse and Alcoholism (NIAAA) convened in May 1992. This working group examined methods for prevention of alcohol-related problems in ethnic communities. Research scientists, service professionals, and community strategists convened in Washington, DC, in May 1992, representing four major ethnic groups: (1) Native Americans and American Indians, (2) Hispanics, (3) African Americans and Black Americans, and (4) Asian Americans and Pacific Islanders. The following objectives of the working group were part of NIAAA's general goal to frame a research agenda:

- to facilitate and stimulate intervention and preintervention research on alcohol-related problems in ethnic *communities*;
- to understand ethnic *communities* as unique resources for effecting certain types of social and behavioral change;
- to identify a model of participatory research that would facilitate collaboration between research scientists, service professionals, and community strategists;
- to understand the process of information transfer with respect to "proven" and promising prevention strategies in ethnic *communities*.

The organization and conceptualization of this working group were shaped mostly by the responses of the invited participants from the four major ethnic communities. The structure provided all groups the opportunity to identify the most effective ways to conduct research to benefit the ethnic and research communities.

This paper has several objectives: (1) to identify the major concepts that framed the research agenda of the working group,

(2) to examine the controversy over the definitions of race and ethnicity, (3) to develop a model of participatory research to be used in alcohol prevention research, and (4) to identify some methodological challenges for applying a participatory research approach to the prevention of alcohol-related problems in ethnic communities.

Concepts

The concepts central to this monograph are: cultural sensitivity, cultural competence, community, and ethnicity and race. Research scientists, service professionals, community strategists and representatives, policy makers, and administrators use these concepts in varying ways. Consequently, there are multiple definitions and meanings imputed to these concepts.

In this paper, concepts and definitions are interpreted as attempts to describe the essence of ideas, not as pronouncements. In the alcohol prevention literature, there is sometimes a finality associated with the definition of a concept that may be inappropriate. For example, Babor (1990, p. 33), in an essay to define alcohol dependence, argues there is no universally valid or veridical view of dependence. Therefore, there is no universally valid or veridical way of evaluating these definitions. What exists instead are *culturally specific* perspectives associated with social constructions of dependence, each of which predicates a different type of meaning.

The preceding description is appropriate to the concepts that guided the working group. For example, the social science literature shows that there never has been a clear cut, universally accepted definition of community, just a consensus of what the term connotes. It is, however, important to examine which groups control the defining process and how these groups use definitions to promote their own ends. Definitions have implications, and different defining groups are promoting different ideas through their definitions. Thus, it is not surprising that, in this monograph, concepts and definitions sometimes have different meanings for the contributors, who represent a variety of backgrounds and perspectives on the prevention of alcohol-related problems in ethnic communities.

Cultural Sensitivity

Within the last decade, the concept of cultural sensitivity has become a very popular one for service professionals and some research scientists. There is a wide range of terms used by researchers in many settings for operationalizing cultural sensitivity. Some of these terms include cultural identity or cultural acumen. Orlandi et al. (1992, p. VI) define cultural sensitivity as an awareness of the nuances of one's own and other cultures. Gilbert, in this volume, defines cultural sensitivity as an awareness by the alcohol researcher that a targeted cultural group may perceive alcohol use differently from the researcher.

Cultural Competence

The concept of cultural competence is the subject of the first volume of CSAP's Cultural Competence Series (1992). In this series, cultural competence is a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups (Orlandi et al., 1992, p. VI). This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons from the community in developing prevention activities- (Hewitt, 1993, p. 5). The population to be served may include any group that has an established set of norms, values, beliefs, and practices that define the identity of that group.

Cultural competence means more than that persons of a certain ethnicity or speakers of a particular language should be employed in a given research project. It means, for example, that researchers work in collaboration with community members to develop culturally appropriate interventions and data collection procedures. In this way, questions of the validity of including culturally competent strategies can be evaluated and tested.

In this volume, the concept of cultural competence is central to the papers of Drs. Gilbert and Moran. Gilbert defines cultural competence as deliberate actions taken by researchers to develop an understanding of cultural similarities and differences in research populations. This includes the systematic integration

into research designs of theory and methods that reflect these variations. Moran adds that researchers need to conduct themselves in a way that is congruent with the behaviors that members of a cultural group recognize as appropriate among themselves. However, this does not mean that researchers behave as though they are members of the cultural group.

Community

People's desire for a community in which they can control the decisions that affect their lives has always been a part of the very nature of society. The idea of community derives from the Latin COMMUNITAS, meaning "common or shared" (Labonte, 1989, p. 87). Many definitions of community have been used (Giesbrecht et al., 1990; Hillery, 1954; see Holder, 1992, for a review of definitions in sociology, political science, and social work). There has been no clear, universally accepted definition of community, rather just a consensus of what the term connotes.

Community is more than some demographic datum; it is the interaction of people working to share decisions and responsibilities. Thus, community is organization, in that it is a group of people sharing values, institutions, and resources. Bell and Newby (1971) define community as a culture that includes values, norms, and attachment to the community as a whole, as well as to its parts. This definition separates communities from mere aggregates of people, who may not share common goals. It also assumes that a community forms a whole greater than the sum of the individuals within it.

Like other concepts used in alcohol prevention research, the crucial point is that the concept of community be explicitly clarified and not remain implicit. Only then is it possible to identify how to bring about intervention *through* a community rather than intervention *in* the community.

The Controversy Over Definitions of Race and Ethnicity

The concepts of ethnicity and race pose many conceptual and measurement challenges. First, according to Hahn (1992), the

categories of race and ethnicity are not consistently defined and ascertained by federal data-collection agencies. Second, there are indications that popular notions of race and ethnic categories differ greatly from those of researchers, data collection agencies and the public. For example, the category "White" is sometimes understood by Hispanics to mean "Anglos," and not Hispanics.

Third, survey enumeration, participation, and response rates are not similar for all racial and ethnic populations (Hahn, 1992). In the 1980 census it is estimated that blacks were undercounted by 5.9% and Hispanics were undercounted by as much as 7.8% (Fay et al., 1988). There is also evidence that individual responses to questions of racial and ethnic identity shift over time. For example, a shift in perception of identity was found in some answers to the 1980 census race question. An analysis of Census data of 1980 shows that 26.5 million people identified themselves as "Black or Negro," while only 21 million claimed African American ancestry (Hahn, 1992).

Apparently some of these problems were corrected by the 1990 census. William Hunt, Director, Federal Management Issues, Government Accounting Office, testified before the Subcommittee on Census, Statistics, and Postal Personnel that federal agencies generally use consistent race and ethnic definitions (1993, p. 2). However, some problems associated with collecting data on Hispanics continued to occur as these had with the 1980 census.

Several researchers studying alcohol and other drug use have reviewed the varying concepts and meanings of ethnicity and race available in the social science literature (see, for example, Cheung, 1990-91a, b; Heath, 1990-91). They document the lack of conceptual clarity and consensus as to what researchers mean by ethnicity and race and how these concepts have been used in research. Cheung (1990-1991b, p. 582) argues that studies of ethnicity and drug use, including alcohol use, have not come to grips with the complex phenomenon of ethnicity. He adds that the inadequate conceptual and operational treatment of ethnicity has been greatly responsible for the lack of attempts in most studies to explain ethnic variations in drug use.

Heath (1990-1991, p. 609) states that attempts to deal with "ethnic groups," "ethnicity," and related concepts have not been

as informative as many social scientists had hoped and expected. The literature that examines differences in drinking patterns among various "ethnic groups" in the United States is logically inconsistent because differentiation of categories is not based on any uniform criteria.

Consequently, there are many problems in doing comparative studies within and across ethnic groups. We need to recognize in alcohol prevention studies the cultural diversity *within* and *among* ethnic groups, as well as similarities among the groups. Similarities among ethnic groups are noted in that the drinking practices of ethnic minority groups do not shape nor necessarily reflect the normative patterns of mainstream groups in the United States. A second similarity among the ethnic groups is the frequent "ghettoization," in a political and economic sense, of communities that are labeled as "Koreatowns" and "Chinatowns." A third similarity is the extent to which alcohol outlets tend to congregate in some ethnic communities.

As previously noted, diversity *within* ethnic and racial groups exists. During a working group discussion of the papers on Black Americans and African Americans, several African American perspectives were evident. African American communities are not monolithic.

This diversity gives rise to some questions: Is there a need for standardized identification of race and ethnicity in databases? Is this possible to accomplish? Is ethnicity measurable? In April 1993, William M. Hunt, testified to the Subcommittee on Census, Statistics, and Postal Personnel that race and ethnic data are among the most complex and controversial data collection efforts undertaken by the Federal Government. Furthermore, he argues that race and ethnicity are not objectively definable characteristics, which makes measurement difficult. As ethnic populations grow and change, biracial and multiethnic children of intermarriages are likely to increase, making precise measurement even more difficult. These problems may result in increasing pressure from new groups for identification on the census form (Hunt, 1993, p. 2).

Peterson (1987, p. 232), a demographer, argues that there is no way of achieving a classification of ethnic groups that satisfies

all of the important governing principles of science, law, politics, and expediency. He describes the job of the Bureau of the Census as a mission impossible, and not one of its own choosing.

For this working group, the major ethnic groups were selected from those in the Ethnic Minority Announcement of 1991 published by NIAAA, and those ethnic and racial groups identified by the Federal Government census classifications as the four largest and most widely recognized ethnic and racial groups: (1) Black Americans, (2) Hispanic Americans, (3) American Indians and Alaska Natives, and (4) Asian Americans and Pacific Islanders. However, there is some degree of inconsistency among the contributors to this monograph who use different terms when describing the same ethnic groups.

The definitions of race and ethnicity that guided some contributors to this monograph are drawn from the definitions of Hewitt (1993, p. 5) and Orlandi et al. (1992, p. VI). Race is a socially defined population that is derived from distinguishable physical characteristics that are genetically transmitted. In the same volume, ethnic is defined as belonging to a common group—often linked by race, nationality, and language—with a common cultural heritage and/or derivation.

In sum, in health research and in the prevention of alcohol-related problems, populations are commonly divided by categories of race and ethnicity. This categorization assumes that race and ethnicity are valid concepts that can be correctly identified (Hahn, 1992). This has not been proved to date. It is possible that race and ethnicity cannot be readily assessed using survey techniques.

Participatory Research: A Rational

There are several methods of scientific inquiry and many versions of doing scientific research, depending upon the research situation, the researchers, and the phenomena being studied. Epistemologies of science and the techniques of data collection and analysis have considerable effect on what we study, how we study it, and how we relate to “subjects” (Chesler, 1991, p. 758).

In the formulation stage of the working group, several participants voiced the view that much of the research produced by the scientific community was not useful to practitioners, to program strategists, or to service agencies in ethnic communities. Because of their experience with academic researchers, these service professionals were concerned that, again, their voices would not be heard over those of research scientists. This view is reinforced by Johnson (1993, p. 27), who notes that many clinicians in the alcohol field voice the same concern. Research scientists' knowledge about alcohol problems does not ring true to the clinician's experience with alcohol users in the community outside the research world.

A partial explanation for these views is grounded in the community members' experiences and perceptions of how research scientists conduct their research in ethnic communities. First, the traditional mode of scientific inquiry used by academic researchers and its accompanying methods often do not fit the nature of ethnic communities and their goals of social change. Second, the traditional scientific model does not involve participation by the community in the identification of the prevention intervention. Third, ethnic communities are not organized with sets of rules for the accumulation of scientific knowledge. Such rules are largely quantitative, and more closely approximate secondary relationships rather than the primary relationships that are often characteristic of ethnic communities. Finally, the traditional model of research serves to maintain the power of academic researchers to control the knowledge generation process and, consequently, the alcohol prevention interventions to be imposed on the ethnic communities.

The participatory research model seems to fit with the purpose that many contributors to this monograph hold: bringing about intervention *through* rather than *in* a community. If we are to meet the second objective of this working group, to better understand ethnic communities as unique resources for effecting certain types of social and behavioral change, then more than one model is likely to be useful to improve both our academic and practical knowledge of the social, economic, political, and cultural diversity of ethnic communities. If we are to be effective

in alcohol prevention interventions, it is necessary to understand the richness of experience, for example, of growing up Black or Hispanic in White America. An opportunity to understand this diversity is lacking in the statistical generalizations derived from epidemiological surveys, which are rarely of practical value to prevention and treatment designers (Gilbert, 1993, p. 3).

The Participatory Model

There are many definitions of participatory research. One prevention researcher defines it as "research in which members of the intervention population share equally with researchers in research planning, implementation, evaluation, and dissemination of results" (DeCambra et al. 1992, p. 3). Using this conceptualization and the ideas of Chesler (1991), a participatory model is developed and discussed below.

A comparison between the traditional research model and the participatory model is offered as a way to enlarge the options that prevention researchers consider when attempting to bring about intervention *through* rather than *in* a community. A comparison of two models of scientific inquiry in Figure 1-1 provides a basis for exploring the application of a participatory model to the study of alcohol prevention research in ethnic communities. These models, or "ideal types," rest upon the assumptions underlying two modes of scientific inquiry: deduction and induction (Strauss, 1987).

The traditional model of research is grounded in deductive inquiry. As shown in Figure 1-1, the goal of research is to advance academic knowledge by applying the basic rules of verification, including standardized measurement devices, and the establishment of "distance" between the investigator and the field of study. The research process is controlled by the researcher, and the research results are published in scientific journals. The traditional research model has been and continues for many research scientists to be the model "par excellence" for maintaining the scientific integrity necessary for the cumulation of knowledge.

A participatory research model is grounded in inductive inquiry. As shown in figure 1, the goal of research is to advance

Figure 1-1

ALTERNATIVE MODELS IN ALCOHOL PREVENTION RESEARCH

	Traditional Research	Participatory Research
Goals	Advance Academic knowledge Evaluation of services	Advance practical knowledge Intervention
Methods	Positivist and deductive Standardized measurement Replicability Experimental design	Interpretive and Inductive Measures generated in response to local situation Quasi-experimental design
Researcher/ Community Relationships	Researcher controlled Researcher separate from the community Objective through distance	Co-control Researcher a part of the community Objectivity through reflexivity
Research Subjects	Passive subjects	Active subjects
Research Issues	Determined ahead of time Demonstrate group "effectiveness"	Evolving from experience in the community Interventions through the community
Research Funds	Controlled by granting agencies	Co-control; access to resources
Data Ownership	Researcher owned	Community and Research
Research products	Scientific articles in	Community reports scientific journals and interventions

This figure is adapted from the models of Chesler (1991) and DeCambra et al. (1992).

practical knowledge and to provide interventions *through* the community. The community shapes the research process by actively participating with the researchers in all phases of research development. Ethnic groups are included at all levels from investigators to interviewers (DeCambra et al, 1992, p. 8). The research process itself takes on different dimensions when the participants help to define the interventions. This is illustrated again by the models that follow.

Singer (1993, p. 19), an anthropologist, compares a researcher-centered model and a community-centered model. These models closely approximate the two models in figure 1. He describes the research-centered model as university and academically based research, guided by the interests of the researcher, who is the primary beneficiary of the public and professional recognition bestowed on the research. Furthermore, the academic researcher decides if and in what form the findings will be available to the participants. Often, the researchers leave little of value in the community when the research is completed. This description by Singer is similar to the traditional model shown in figure 1.

The community-centered model described by Singer closely approximates the participatory research model in figure 1. Researchers and community members engage in continuous discussion as a team to identify the issues and concerns as perceived by members of the community. In addition, an effort is made to develop the research skills of the ethnic community members.

Participatory Research in Alcohol Prevention Research

A participatory research model in which research scientists and service professionals in the community collaborate to decide the prevention strategy is likely to increase the opportunity for researchers to gain access to ethnic communities and to develop relationships based on trust. These relationships are necessary for the development and testing of prevention strategies in ethnic communities (Kelly, 1988).

Access and Trust

Access to do research in ethnic communities is a complex issue. As the contributors to this monograph demonstrate, many ethnic communities have experienced negative relationships with researchers, who have shown more interest in their own research than in the welfare of the community. For example, if researchers lack sensitivity to the history of the community, they are unlikely to attain access very easily. Furthermore, they may create a response from the community that will keep others in the future from gaining access. A few of the members of the working group reported that communities often perceive that academic researchers view the community as a field laboratory to be used primarily for the benefit of the research community. This may result in researchers publishing results about a community that portray the community in a negative or stereotyped way. Under these perceptions, the community is not likely to grant access to research scientists to conduct further studies.

Language differences, lifestyle differences, and the time dimension often create social distance between academic researchers and ethnic communities. Often members of ethnic communities report that academic researchers do not work with the community to find out what the community needs. It takes time to develop a sense of community and time to develop outside community relationships.

Trust is one of the most important variables in how an ethnic group evaluates a potential researcher (Perkins and Wandersman, 1990). If we are to gain access and develop trust from community members, research scientists need to be knowledgeable of the social organization and the lifestyle in these communities. The use of a participatory research model will more likely result in better understanding of the unique resources for effecting certain types of social and behavioral changes in ethnic communities.

Participatory Research: Methodological Challenges

Giesbrecht and Ferris (1993) argue that the negotiation of community-based research projects presents great potential and great

risk. Acknowledging this, it is especially important at this stage of our knowledge to understand and analyze the social processes that take place in the *interaction* between research scientists and community members. It is in the interaction process where the prevention of alcohol-related problems can be found. It is in the interaction and negotiation processes where the hazards lie.

Many methodological challenges for applying a participatory research model to alcohol prevention research are identified in this monograph. The following list of issues grew out of the working group discussions. These need to be addressed in a systematic and critical way before the participatory model will be viewed as a legitimate mode of scientific inquiry by research scientists:

- The limitations and strengths of the participatory model for meeting the two goals of advancing scientific knowledge and advancing practical knowledge;
- The need to address the mix of research scientists, service professionals, and community strategists on investigator review boards to improve the peer review process and funding opportunities for community organizations;
- The need for additional funding of research projects necessary to allow the time that may be needed to include community participation in the multiple phases of the research process; and
- The need to increase the negotiation skills of research scientists and service professionals to include the concepts of cultural sensitivity and cultural competence.

A participatory research model in which research scientists, service professionals, and community strategists collaborate to decide the prevention strategy is likely to increase the opportunity for researchers to gain access to ethnic communities and to develop relationships based on trust. We need to validate whether access and trust are necessary elements for the testing of prevention strategies in ethnic communities.

The *ideology* of the participatory research model is appealing to service professionals, to community strategists, and to some researchers. However, we need to conduct systematic research on the participatory research process itself before accepting it

as appropriate to alcohol prevention research. Research on the "participatory research model" will require institutional innovation within NIAAA, which has been committed to a traditional research model. To do this research will require the acceptance by those in power that the model is appropriate to investigate.

Finally, researchers who are engaged in developing more innovative approaches and models in alcohol prevention research at the community level might benefit from the wisdom of Vanderveen: "To know what one is about and why, is probably the most rudimentary common sense ground rule for all who would participate in science" (1993, p. 31).

Contents of the Monograph

The contents of this monograph follow the agenda of the working group. The monograph presents the state-of-the-art findings on alcohol prevention research in four major ethnic communities as of 1992: American Indians and Alaska Natives, Hispanics, African Americans, and Asian Americans and Pacific Islanders. Research scientists, service professionals, and community strategists collaborated in the working group to explore explanations for these findings, and to frame an agenda for future research.

The remainder of this monograph is divided into four sections. In Part II, Dr. Gilbert and Dr. Moran review the meanings of cultural sensitivity and cultural competence. They show how these meanings are related to community intervention in ethnic communities. Dr. Robinson, a public health professional, is the discussant for these papers on cultural sensitivity. He argues that researchers need to understand the historical context of the communities in which they are trying to conduct research. Without this sense of history, scientists are at risk of being insensitive when conducting their research.

Four papers in Part III address conceptual and methodological issues of conducting alcohol prevention research in ethnic communities. In the first paper, Dr. Pentz compares and contrasts the various models of community research that have been tried, and the implications of alternative models for prevention research in ethnic communities. In the second paper, Dr. Beauvais

presents an argument for the building of an alliance between the two cultures of science and community so that each culture enriches the other. He addresses several methodological issues related to this alliance that are important for the effective blending of these cultures. The third paper in Part III, by Dr. Schinke and Ms. Cole, is an addition to the monograph. We recognized after the working group that we needed to direct more attention to methodological principles when conducting culturally sensitive alcohol prevention in ethnic communities. The last paper in Part III provides an analysis of a successful prevention research partnership. Dr. Rolf, a research scientist, describes in depth each step of the research process. He shows how his research team was able to bridge the gaps between researchers and community strategists by integrating methods, strategies, and the needs of each group. He demonstrates the necessity of collaboration among all members of the research team and the community members.

The four major case studies on American Indians and Alaska Natives, Hispanics, African Americans, and Asian American and Pacific Islanders are presented in Part IV. Within each case study there are three papers written by: (1) an academic research scientist who presents the state of the art findings on alcohol prevention research, (2) a community researcher or service professional who focuses on specific community studies and findings, and (3) a discussion paper authored by a community strategist from the ethnic community. In Part V, the Chief of the Prevention Research Branch, NIAAA, Jan Howard, concludes the monograph with her paper on Framing the Research Agenda.

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Part II

Cultural Issues in Community- Based Prevention Research

2

Conducting Culturally Competent Alcohol Prevention Research in Ethnic Communities

M. Jean Gilbert

Introduction

The terms “cultural sensitivity” and “culturally relevant” have been in use among researchers and service providers for at least 20 years amid some confusion about what they actually mean. More recently, the term “cultural competence” has entered the diversity lexicon (Orlandi,1992). In the past, these terms have usually been operationally defined to mean that more persons of a certain ethnicity or more speakers of a specific language should be employed when a given service arena or research project is targeted to persons of that ethnicity. Without a doubt, participation by members of an ethnic group in the planning and conduct of services or research directed toward that group is one important component in making services and research appropriate and sensitive to group members. Certainly concern for language differences is also critical. However, an understanding of cultural sensitivity, relevancy, and competency in research design rests on a much more complex basis than just these two components. These terms derive their essential meanings from

the concept of culture: what culture is and the important ways that cultures resemble and differ from each other.

A more precise understanding of the meaning of these cultural diversity terms and the issues they raise for research therefore requires a brief initial outline of what is generally understood about the nature of culture. Following this discussion, the culturally associated terms are more fully defined as they are related to the research process itself. The critical need for firsthand experience with the cultural group to be studied is stressed, along with the value of this kind of experience. School-based prevention programs and their evaluations exemplify the way researchers have ignored the multiethnic character of the youthful population, as the next section of the paper points out. Suggestions for more culturally sensitive prevention research designs in school settings are offered. Finally, an argument is made for collaboration among researchers, providers, and community members for the conduct of culturally competent prevention research.

Alcohol Use in the Context of Culture

Culture may be thought of as all the ways a specific group of people adapts to its unique geographic, physical, historical and social niche. A culture is *learned* by its members, largely through the medium of language and interaction, than inherited biologically. Much cultural learning occurs *out of awareness*, through countless acts of modeling and reinforcement—the way, for example, most Anglo-Americans in the United States learn that the “proper” distance between people in friendly conversation is about 2 1/2 to 3 feet, a distance greater than a Middle Easterner would consider comfortable. The process of cultural socialization of group members is not confined to the enculturation of the young, but is ongoing across the life cycle, mediated by peer modeling and pressure as well as group response to historical and structural factors.

The term “ethnic group” is used to designate a group of people with shared understandings and lifeways. Unlike the terms “race” and “nationality,” which denote groups defined

(however imperfectly) by biological and geo/political boundaries, the boundaries between ethnic groups are social constructions created by member self-identification and allegiance to group beliefs and norms. In this paper, the terms "ethnic group," "culture" and "cultural group" are used interchangeably to emphasize this relationship.

The distinctive material manifestations of a culture, such as food, dress, and technology, are readily perceived by persons outside the culture. It is usually not difficult for people to become sensitive to these visible aspects of a culture and to understand their practical implications. For example, most health care providers can readily accept the good sense of discussing dietary practices with immigrant Vietnamese or Cuban patients in terms of the foods that make up their specific cuisines rather than referring automatically to mainstream American food habits.

However, the most important characteristics of a culture are less easily grasped. These are abstract values, beliefs, and perceptions about reality—culturally unique frameworks of interrelated meanings and social constructions. These abstractions are shared to a greater or lesser degree by members of a cultural group (the way a language is shared) and, when acted upon, produce behaviors considered appropriate and acceptable within that group. These invisible features of a culture function together as an integrated whole, each shaping and reinforcing the others. For example, the unique *values* of a group will be supported by *norms*, that is, rules governing behaviors such as alcohol use. The norms then will be reinforced by *sanctions* that provide social consequences for following or breaking the norms.

Through language, members of cultural groups learn to categorize and classify objects, ideas, persons, events, and experiences in culturally unique ways. These cognitive categories and the relationships among them form systems of meaning. The assumptions and premises that make up such a cultural world view are internalized to the point that the members of a culture believe their perspective is "reality" and their view of human behavior to be *a priori* "human nature." So buried are many of these guiding premises that they form a deep structure that shapes thought and behavior unconsciously. Thus it is exceed-

ingly difficult for researchers and service providers who have learned to construct reality through one set of classifications, categories, and meanings to imagine a reality constructed differently or to place the behavior of persons from another culture into a meaning or motivational context other than their own.

The reality of core orientations around which a cultural world view is framed does not mean a culture is static and non-responsive to changes caused by alterations in the social or physical environment. Cultures are modified, sometimes rapidly, sometimes slowly, by cumulative adaption to changed circumstances. Further, individuals within cultures may accept, variously interpret, or refute aspects of their cultural background. Through culture contact, individuals and whole groups may blend or adapt elements from two or more cultures. However, change occurs most rapidly in material culture and very much more slowly with respect to cognitive structures, meaning systems and interaction patterns.

The cultural meanings surrounding a specific trait such as alcohol use are derived from just such relational matrices. Alcohol use has been nearly ubiquitous in the societies of the world; hence most cultures have complex sets of premises and assumptions that guide initiation, normal and deviant use, and the perceived role of alcohol in social interactions. There is plentiful evidence that alcohol-related norms and behaviors vary and are integrated differently across cultural and subcultural groups (Heath, 1987). Communicating, assessing, and measuring prevention effects in a specific population becomes problematic if cultural motivations and meanings around alcohol use are not understood and reflected in program design and evaluation. From a scientific point of view, the internal validity of research measures may be seriously threatened.

Cultural Sensitivity, Relevancy, and Competency Redefined for Alcohol Research

The terms relating to culture cited earlier in this paper can now be better understood. Cultural "sensitivity" refers to an aware-

ness by the alcohol researcher that a targeted cultural or subcultural group may very likely perceive alcohol use in a relational context different from his/her own and that modifications may need to be made in research strategies to accommodate those differences. Cultural "relevance" means that a concept, prevention modality, or research strategy must be salient to the group to whom it is directed, that is, understandable in their terms. Cultural "competence" embodies both concepts in deliberate actions taken by researchers to develop an understanding of cultural similarities and differences in research populations and to *systematically* integrate into research designs theory, strategies, and methods that reflect these variations.

Lloyd Rogler, director of the Hispanic Research Center at Fordham University, has given us an excellent description of culturally competent research (Rogler, 1989). In this brief article Rogler's major point, and it is absolutely critical, is that no specific act or set of finite acts performed on research makes it "culturally sensitive." Culturally sensitive research is an ongoing, systematic process. He states:

In general, research is made culturally sensitive through a continuing and open-ended series of substantive and methodological insertions and adaption designed to mesh the process of inquiry with the cultural characteristics of the group being studied. The insertions and adaption span the entire research process, from the pretesting and planning of the study, to the collection of data and translation of instruments, to the instrumentation of measures and to the analysis and interpretation of the data (Rogler, 1989, p. 296).

Culturally Competent Research: Essential First Steps

The first step while conducting culturally competent research is the hardest. Researchers need to acknowledge the possibility that they may know very little about research populations different from their own if they have not had firsthand, in-depth experience with the group. Acquiring essential knowledge about a culturally defined research population should occur before

formulation of a research design and methods. Researchers will need to go through the painstaking process of examining and comparing their own cultural assumptions with those of the groups they are studying at every step of the research process. However, no time is more critical than in the theory-building stage of prevention research, when hypotheses about what interventions might be effective in a given population or across different populations are formulated and measures for assessing outcomes are designed.

Firsthand experience is the best corrective for testing one's assumptions and becoming knowledgeable about groups different from one's own. It involves the researcher's direct immersion in the culture of the group to be studied. This means that the researcher who is designing the research (not his or her research assistant) needs to go to the locale where the group resides and/or consumes alcohol, talk to leaders of the group, have conversations with a wide range of alcohol consumers themselves and observe settings, occasions, and actions involving alcohol use. It is helpful for a researcher to interview local-level treatment providers and health professionals, particularly those of the same ethnicity as the targeted group. Firsthand experience is greatly amplified if a research team includes one or more researchers drawn from the group(s) to be studied.

The strategies used by the Western Behavioral Study Group at Colorado State University at Fort Collins are instructive in this regard (Beauvais and La Boueff, 1985; Oetting, Edwards and Beauvais, 1989; Edwards and Edwards, 1989). This research group has conducted school-based studies among a variety of cultural groups only after acquiring on-the-ground information about the structure of the local community, considering local leader input and assessing the local social context for alcohol and other drug use. These and other qualitative and archival data inform the design of their surveys and augment and contextualize their research findings.

Such initial community contact is a kind of experiential pre-testing of theory and assumptions about what actually is going on within the cultural group. This step is important whether the researcher plans to focus exclusively on one specific ethnic group

or intends to include the group in a comparative study or survey. In the latter case, all the groups should be treated in this careful manner.

Cultural Constructions in the Informal Sector

On-the-ground familiarity with a target population is particularly important because most alcohol-related behavior takes place in the unmanaged or uncontrolled sectors of society. It is in this sense "insider" behavior. Close attention must be paid to the social interactions and subjective cultural elements that are relevant to alcohol use within a given cultural context, and these do vary across and within groups. Alcohol consumption occurs, in the main, in the informal arena, that set of interactions with family, friends, and work associates that are generally beyond the direct control (and scrutiny) of institutions and policy makers (McKnight, 1987). Mauss et al. (1988), in pointing out that school-based prevention programs rarely have been shown to modify behavior or even to have long-term effects in changing adolescent attitudes toward alcohol use, correctly note that the factors most critical to the shaping of adolescent drinking behavior, such as peer influence or socialization, are imperfectly understood and are mostly beyond the purview of the school.

Drinking is frequently woven into the content of friendship bonds in same-sex as well as opposite-sex social contexts, and the meanings and expectations attributed to alcohol use in such contexts is important to an understanding of how peer pressure influences drinking behavior.

Then, too, alcohol use, because of its embeddedness in whole matrices of social meaning, often takes on symbolic or associative connotations that must be considered in designing interventions for specific groups. For example, recent research among Mexican-American women (Gilbert, 1991) shows that as these Latinas acquire higher incomes and education, usually accompanied by generational distance from immigrant status, more frequent and heavier use of alcohol is just one of many concurrent role-transfiguring changes occurring in their lives. These include increased

social freedom, greater interpersonal and sexual assertiveness, and more participation in public life. Issues around choice and self-determination may thus become entangled associatively with alcohol use in complex ways that need to be considered in prevention programs and research.

Important features of the informal social world would also include culturally shared beliefs about appropriate persons and communication strategies for socialization of youth in the use of alcohol as well as relevant sanctions for controlling alcohol use among youth and adults. For example, many cultures have very negative views of individualistic, autonomous decision-making among young or even not-so-young people. It may come as a surprise, then, to some prevention program designers and researchers that the kinds of self-assertive and self-determination practices designed to "inoculate" youth against alcohol and other drugs are not the kinds of behaviors reinforced by many Vietnamese, Mexican, Filipino, and Native American parents in day-to-day life. The effectiveness of such interventions may thus be attenuated by countervailing emphases in child-rearing practices unknown to culturally oblivious researchers and program designers.

Further, sources of individual and group self-esteem, group-appropriate social skills, and expression of affect, as well as alcohol-related problem recognition and definition, are also culturally constructed social characteristics that might be expected to vary, sometimes dramatically, across cultures (Fisher, 1988; Hall, 1976). These social features bear directly on interpretation and acceptance of the content and assumptions of most cognitive and developmental prevention strategies currently being used in prevention programs. Since most of the content and strategies are based on mainstream, middle-class Anglo social realities, the cultural fit of the programs *may* be poor (Globetti, 1989).

Cultural premises and assumptions affect respondents' interpretation of questionnaire and interview protocols. It has been pointed out elsewhere that important cultural differences are not easily captured by researchers using the categories of thought derived from the "professional research culture" (Rogler, 1989). Attempting to fit the social constructions of one culture into the

language and classifications of another often creates distortion and suppression of cultural variation (Kleinman, 1977). There is evidence, for example, that the meaning of Likert scale anchors may vary across ethnic groups (Baranowski, Tsong and Brodwick, 1990). A culturally oblivious researcher may never know that respondents have not interpreted the question in the manner intended. Sensitivity to these issues evolves out of face-to-face testing, reviewing, and norming of instruments with members of the groups being studied.

Unfortunately, there has been little research focused on uncovering inter- and intra-group differences as they might relate to the cultural consonance of prevention approaches. However, the bottom line is that policymakers, program designers, and researchers may create whatever programs they like, but their effectiveness will largely depend on the consent or "buy-in" of individuals and groups within the community's informal sector. This they will *not* do if the "social map" reflected in programs designed to modify their behavior and research designed to assess its success doesn't match the "territory" of their social world.

Prevention Research is Usually Local-Level Research

Experiential familiarity with a research population is especially important in prevention research for another reason. Prevention research differs from many other types of research in that it is usually carried out at the local level, within a defined geographic region, whether it is a city, neighborhood, school district, or school. The approach will necessarily be based on numerous assumptions about the drinking behavior and drinking contexts of the local-level group or groups for whom it is designed.

From what source will these assumptions be derived? Certainly not from national epidemiological data. Given the tendency for ethnic groups to cluster in geographical regions, local-level prevention research is usually focused on, say, Mexican Americans or Puerto Ricans (not Hispanics/Latinos), Sioux or Navajos (not Native Americans), or Filipinos or Chinese (not

Asians). Much of the national epidemiological and risk factor data available on aggregate groups labeled Hispanics, Native Americans, and Asians are of marginal utility because it masks important differences among the highly distinct cultures within these aggregate categories (Trimble, 1990-91). Comparisons across distinct ethnic groups show that there are clear differences in alcohol and other drug use patterns among Cubans, Puerto Ricans, and Mexican Americans (Austin and Gilbert, 1989; Caetano, 1988), among Japanese, Korean, and Chinese (Chi, Lubben and Kitano, 1989) and among the various Native American tribal groups (Weisner, Weibel-Orlando and Long, 1984). There are also differences within each of these groups among immigrants and later generations. To design culturally sensitive prevention program assessments, the researcher needs to know a great deal about the specific characteristics of the cultural group in the particular geographic locale where the prevention program is to take place.

Structural and historical factors impacting local-level cultural groups need to be understood by community or school-based prevention program planners and evaluators who want their projects to be culturally competent. The influence and power structures of cultural groups differ across communities as does the manner in which they are integrated into the larger community (Gilbert and Cervantes, 1987). Mobilizing grassroots community support within an ethnic community around, say, liquor licensing policies and other controllable environmental factors relating to alcohol-related problem prevention requires knowledge of the influence structure within a community. Who are, for example, the individuals and groups capable of involving and mobilizing a primarily immigrant community? Are there historical stratifications, coalitions, and polarized perspectives operating within a local cultural group that could be inimical to the success of a community action/public health prevention approach and its evaluation?

If the program is to be community-wide, targeting multiple cultural groups, it would be important to know how integrated into or alienated from the overall community are the various discrete populations within its geographic boundaries. Are there

barriers such as language, legal status, and economic factors that would limit any of the groups from being included in the planning, implementation, and assessment of the intervention? Are there deep historical divisions or resentments between groups that would preclude trust and cooperation? Given the size of the Black, Latino, and Asian populations in most urban areas, these would be important considerations in conceptualizing a culturally sensitive prevention and research program addressed to a multi-ethnic community. Up-front research, sensitive to these possibilities, would allow for the discovery of problems and barriers so that efforts could be made to overcome them.

On the other hand, if the research includes a comparison of several communities within a geographically dispersed and broadly defined population, e.g., Native Americans in the Southwest, it is important to determine whether there are structural or cultural features across the groups being compared that would render them non-comparable or would alter the basis for comparison. Attention to these issues is evident in prevention research conducted by Philip May et al. (1983), who, through close interaction with Native American groups, have become aware of important differences in the way cultural traditions in various Native American groups impact on drinking behavior. These researchers integrate this knowledge in the design of prevention research projects. Stephen Schinke and his colleagues (Schinke et al., 1985) have conducted prevention research among several Native American groups with modest success, using culturally sensitive methods. They use an "indicated prevention modality" which is highly group-specific, with all curricula materials tailored to the cultural group. Outcome data showed reduced self-reported rates of alcohol, tobacco, and other drugs.

An Example of Failure to Consider Cultural Issues: School-Based Prevention

School-based prevention research projects seem particularly lacking in cultural awareness or sensitivity. The fact that youth

from variant cultural groups attend the same school may incline researchers to view school populations as essentially homogeneous when often they are not. The geographic clustering of specific ethnic/cultural groups within urban school populations has been a demographic fact for many years. And, in many prevention programs, a school-based component forms the core of community prevention activities (Pentz, 1986). Thus it is puzzling that in projects with large sample sizes with significant multi-ethnic proportions, little is mentioned, in discussions of the planning, implementation, and outcome, about ethnic or cultural issues (see, for example, Pentz, 1986, on the organization of a large prevention program in Kansas City or Ryan and Reynolds, 1990, on the design of a community action approach to the prevention of alcohol problems in San Diego).

It is hard to reconcile the fact of huge ethnic populations in the schools with the abundance of White only or White-dominated school samples reported in the prevention research. Schaps et al. (1981), having reviewed 127 drug prevention evaluations conducted between 1968 and 1977, noted that nearly 70% failed to specify race or ethnicity, and only three programs served populations with more than 50% minority students. In Tobler's meta analysis (1986) of 143 adolescent drug and alcohol prevention programs conducted in the 1980s, only 12.6% of the programs were found to serve special, mostly ethnic/racial, populations, though these were found to be among the most successful in changing alcohol and other drug behavior.

The manual for a conference at University of California, San Diego titled "What Do We Know About School-Based Prevention Strategies?" (1990) contained nearly 50 papers reviewing evaluated alcohol, tobacco, and other drug prevention projects. "Here's Looking at You," "DARE," "STAR," and "Project Alert" were among the approaches evaluated. Judging by the communities in which many of the prevention programs were conducted, there had to have been significant proportions of specific ethnic groups within the study samples. However, ethnicity was a variable in the analysis of only two of the evaluations (Elickson and Bell, 1990) and was mentioned in only three of the review essays (Kumpfer, 1989; Glynn, 1989; Tobler, 1986). Most researchers,

judging by their analyses, were completely uninterested in the possibility of differential outcomes by ethnicity or cultural group.

Another critical description of school-based alcohol and other drug abuse prevention curricula being used across the nation during the 1988–89 school year, *What Works* (Rogers, Howard-Pitney and Bruce, 1989), includes a category called “cultural sensitivity.” Under this category, prevention curricula were rated in terms of the degree to which they avoided ethnic stereotypes, portrayed a variety of social groups and lifestyles in their materials, and included suggestions on how to make the materials more culturally relevant for special populations. Of the 30 prevention programs reviewed, two were rated excellent by these standards, nine good, 11 fair, and for seven there was insufficient information. It was unclear whether the raters or the outcome evaluations assessed the efficacy of these programs among students of differing ethnicity. Again, the possibility of differential effectiveness seemed to be a non-issue. This is a significant deficit in prevention research, as noted in a recently published critical review of drug abuse prevention programs and their evaluations (Gerstein and Green, 1993). This review points out that there are “two worlds” of drug use: one middle class and White, the other poor and mostly ethnic/racial groups, and that substance use patterns and the social meanings behind those patterns vary dramatically across these two worlds.

Some Suggestions for Culturally Competent School-Based Research

Large-scale school-based prevention programs can be made to produce useful data on ethnic subcultures through incorporating appropriate demographic variables and including analyses of data by ethnicity. Many school districts, particularly those in large urban areas, have school populations in which specific ethnic subgroups are very well represented, providing an excellent opportunity for the design of school and community-based alcohol and other drug prevention research that carefully

explores the degree to which culture/ethnicity moderates the effects of alcohol and other drug abuse prevention approaches. Results from such studies would begin to help us assess whether or not ethnic-specific prevention programs are needed for youth from various cultural groups and could point the way to unique alterations in program design that might enhance the effectiveness of a prevention approach when used with a particular group. A hint of what might be found in adopting such an approach lies in the research of Graham and colleagues (1990), who evaluated short-term program effects of a social influence program among Los Angeles 7th graders. There was a significant positive program effect for Asian students, no significant positive effects for Hispanic and Black students, and no effects for White students. Moreover, all positive program effects were among girls, suggesting that gender role norms interact strongly with ethnic group differences.

The challenge lies in taking such research several steps further by assessing variation in the sociocultural elements that may be related to variation in program outcome for different cultural groups. The incorporation of culture as a variable in the design of prevention research projects from the outset would compel consideration of other sensitivity issues: careful and specific designation of the cultural groups participating, construction of appropriate sampling frames, effective sample recruitment methods, language and translation concerns, cross-cultural pretesting and norming of program materials and evaluation instruments, and methods of involving community members in community-wide planning and program implementation.

Collaboration Between Researchers, Local Level Providers, and Community Members

Whether for school or community-based prevention approaches, attention needs to be paid to the development of research strategies that can consider the untidy and relatively uncontrollable reality of the informal world outside agencies and institutions

and can also provide a bridge between these unstructured and structured arenas. Such designs will necessarily be the result of collaboration between all of the stakeholders: community members, service providers, and researchers. Community members can offer essential information about and access to the target community. Service providers can supply specific information and indepth knowledge about alcohol-related behavior within the community. Researchers bring knowledge of research design, measurement, and analysis.

It is very difficult to do community-based research in a cultural group without getting the cooperation and buy-in of community members and leaders (Orlandi, 1986). This may require that researchers and service providers work together as a team with community members in the formulation of goals for the prevention project. It may be that community criteria for the success of the intervention will differ from those of the project evaluators, and these criteria will need to be considered in the evaluation design. Researchers will also need to give assurances to the community that the information gathered in the project will be disseminated widely and in a form understandable to community members (with appropriate concern for issues of confidentiality). When trust is established and the sincerity of the providers and researchers is plain, there is much that community members can do to enhance researchers' understanding of the community and smooth the way for the intervention and evaluation.

Community members can provide an overview of their group's history, social and political makeup, and geographical layout. They often will have a less specialized and more general view of the community's needs and problems than will the providers of alcohol or other specific services. Community members will often provide entry into private and public settings and occasions where drinking behavior takes place, and they can offer insider interpretations on the meaning of behavior that should be cross-checked among many community persons from varying sectors. If language is an issue, they are often invaluable in locating interpreters and bilingual people for staffing a survey or field team. They are familiar with the local media and can

point out appropriate print and other media that might cooperate in a prevention effort. Importantly, they can warn against obstacles and barriers to the successful completion of the project.

The alcohol and other drug-related service-providing agency personnel, if available in the target community, can provide introductions, sometimes a base from which to operate a research effort, and ongoing information on the feasibility of prevention programs and evaluation methods as they might be carried out in specific target groups within the community. They will be among those most interested and, hopefully, benefited by the research, and so their stake will be high.

Information about family dynamics, acculturation concerns, and special health issues are among the subjects that can best be learned from the service-providing sector of the community. Group-relevant theoretical models of prevention research can be based in part on the clinical experience of counselors, psychologists, social workers, and other service providers working with a specific population (Santistevan and Szapocnik, 1982).

Collaboration between researchers, community members, and providers is often difficult in the initial stages, as each group brings to the effort very different perspectives and goals. Researchers do not like to hear that the variables making up their hypotheses are not salient to the ethnic population in the form they may have construed them, or that the information that their research seeks to develop is of little interest and utility to service providers. Providers, in turn, do not like to be confronted with the notion that their pet etiological theories must be operationalized and subjected to rigorous testing. They may be threatened with the notion of an evaluation procedure even if it is not evaluating their programs or capabilities. Community members want assurance that the programs for which they provide input are acceptable and successful in obtaining desired outcomes and may be cynical about yet another program or approach to a seemingly intractable problem. Nevertheless, prevention research models hammered out in this type of conceptual and action collaboration can build trust and accuracy and are likely to hold more promise for ethnic alcohol and other drug use prevention research than are models based on researcher theorizing alone.

Conclusion

This paper began with a recitation of some of the terms associated with cultural diversity as they are used in describing service provision and evaluation research. It was argued that these terms only have relevance if the concept of culture as it relates to values, norms, and meanings surrounding behavior are understood. Numerous ways in which cultural variables affect alcohol use and its meaning within cultures were reviewed. Then, first-hand experience with research populations during the initial stages of theory formulation and research design was recommended as a corrective to possible ethnocentric assumptions and premises that might bias research approaches and interpretation of results. Cultural competency in research approaches was defined as the active consideration and integration of cultural factors in all phases of the research process. The lack of attention to cultural variables in school-based prevention and evaluation was discussed as illustrative of cultural obliviousness by many investigators. Researchers and prevention program planners have consistently ignored the vast heterogeneity of school populations during a time of increasing cultural differentiation in the nation's populace. Finally, the paper presented a rationale for research approaches involving collaboration between ethnic communities, program providers, and researchers.

Prevention research is applied research. It points the way to effective policy making and action taking. In requiring that ethnic minorities and women be included in health-related research studies, the National Institutes of Health notes that there are clear "scientific and public health reasons" for attention to these populations. The mere inclusion of these groups in research populations is not scientifically justifiable, however, unless research is designed to allow for the unique characteristics and needs of these groups, if they do exist, to be revealed.

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3

Culturally Sensitive Alcohol Prevention Research in Ethnic Communities

James R. Moran

Introduction

During a recent interview with an Indian high school student from a Southwest tribe, an Anglo investigator in an attempt to establish rapport casually asked what class period the student was missing to take part in the interview. When the student responded that this was biology period, the investigator related that biology had not been his favorite course—especially when he had to dissect frogs. After a long pause, the student responded, “Dissecting frogs is not part of our biology class. It is against our religion. They are sacred to us.” (Koester, 1993).

Being sensitive to a person’s culture is an important consideration for those of us who carry out research; and, as the above example shows, even the best of intentions is sometimes not enough. My purpose in this paper is to examine issues of cultural sensitivity in relation to prevention research in ethnic communities. I will explore these issues from both individual and institutional perspectives and will provide guidelines for culturally sensitive research. Although specific examples relate to my experience and familiarity with American Indian populations, the general principles apply to other cultures as well.

Background

Room (1990) characterizes much prevention research as an unstable mixture of mismatched frames of reference and agendas: those of the community members and those of the researchers. Community members working with prevention programs are immersed in reducing alcohol-related problems in their communities. To mobilize support for their efforts, they often believe intensely in what they are doing and in the value of their programs. On the other hand, researchers must maintain a degree of impartiality regarding the programs. The researchers' role is often to determine program effectiveness and report the findings, positive or negative. Thus, researchers' portrayals of community efforts are not always positive and may not sit well with community members. Furthermore, publication of evaluation results may bring unwanted and adverse attention to communities. For many community members, researchers are an unwanted nuisance, one generally imposed on the community by outside funding sources. Evaluation is often viewed as done not "for" the community, but rather "to" the community.

These issues are likely to apply to most communities; however, they are particularly important when research is focused on prevention efforts taking place in ethnic communities. A major reason for this is that besides the ordinary insider-outsider concerns, research dealing with these communities requires understanding of and sensitivity to the particular culture. An important layer of this understanding is to see the historical nature of the relationship between the dominant culture and the target community. For example, in the case of American Indians there exists a 500-year history of oppression and domination—at times approaching genocide. Similar histories are present for other groups, so that many ethnic communities have a historical distrust of the dominant society (Lockart, 1981). When the research is seen as imposed on prevention programs from outside the community, this distrust is likely to escalate and form a significant barrier. In this situation the evaluation is not likely to produce useful results for either the target community or the larger society. To overcome this we must find ways to make research

and evaluation relevant to communities. One way to approach this is to be sensitive to cultural differences and to treat such differences with respect. To the extent that we fail to do this, at best we will have little constructive impact and at worst we will produce negative consequences. Two brief examples may help clarify this issue.

Barrow Alaska Study

In the summer of 1979, the Department of Public Safety in Barrow, Alaska, began a research study to obtain data that could be used to establish more effective prevention programs for the Barrow community. A key part of this study was a survey of native persons in the Inupiat community of Barrow to examine drinking behavior and attitudes about alcohol use (Foulks, 1989). A consulting firm in Seattle was hired to conduct the research. This firm subcontracted with an established research center in Philadelphia to carry out the community survey. A steering committee consisting of local Inupiat leaders and a technical advisory group consisting of mostly non-native professionals from Barrow agencies were formed to provide input into the research process.

The community survey revealed serious and substantial abuses of alcohol including excessive drinking, family problems, fighting, and frequent blackouts among many respondents. However, for this paper, it is not the results of the study that are important. It is the research process and particularly the manner in which the results were reported that provide guidance about cultural sensitivity.

After reviewing a draft of the study report, the technical advisory committee said that it was difficult to read, verbose, and ambiguous. In addition, the committee indicated that the draft report imposed outside standards on the native society without reflecting attitudes and values of the community (Foulks, 1989). In response, a series of meetings between the research team and the technical advisory group took place over a period of several months to resolve these issues. The research team also presented the results to the steering committee and scheduled a town meeting to present the results to the community.

This process appears reasonable and sensitive to community concerns; however, positive effects of the study were frustrated by the next occurrence. The Seattle consulting firm and the Barrow Department of Public Safety decided to release the report to the press prior to the town meeting to shock the Inupiat into action to control the alcohol problem (Foulks, 1989). The press conference took place in Philadelphia, and the news release was picked up by the national wire services. The study results received widespread and sensational coverage, thus furthering the stereotype of the drunken Alaska Native. However, rather than shocking the community into action, the public release of the study results angered the community. The public exposure brought shame on the community and a backlash of resentment and defensiveness from many community members. The research team belatedly recognized the mistake of the premature and public release of the study results; however, the Barrow alcohol study remains an illustration of a lost opportunity for research to contribute to a community's well-being.

Blue Bay Study

A second example concerns the Blue Bay Project, an Office for Substance Abuse Prevention (OSAP) funded program located on the Flathead reservation in Montana. Developed by the Tribal Substance Abuse Program with the assistance of the Cultural Committees from both the Salish and Kootenai Tribes, the program incorporates many components focused on strategies for reducing or preventing alcohol use on the reservation (Whiting-Sorrell, 1991).

Two key points concerning the annual OSAP evaluations of Blue Bay are important for this paper. First, much of the evaluation work has been contracted to a university-based Indian researcher who had extensive experience in both alcohol-related research and in evaluation involving several different tribes. While not a member of the Salish or Kootenai Tribes, this researcher was aware of relevant cultural issues. Second, the evaluations had been carried out by this researcher over a period of several years, thus enabling the establishment of a relationship with the community and program personnel.

Lessons from These Community Studies

The Barrow study and the Blue Bay evaluations represent alternatives for approaching research in ethnic communities. The Barrow research used mainly non-native outsiders in a one-shot study that occurred over a brief time span. No ongoing relationship was developed, and it appears that what trust was established was destroyed by the premature public release of the study results. On the other hand, the Blue Bay research employed an American Indian as the lead researcher and the research was conducted at intervals over several years, thus establishing legitimacy and decreasing the insider-outsider gap. In short, the Barrow study represents a lack of cultural sensitivity while the Blue Bay evaluations demonstrate sensitivity to cultural issues.

These examples illustrate that to accomplish culturally sensitive research, two separate but related issues must be addressed. First, we as individual researchers need to be sensitive to cultural differences and treat such differences with respect. Second, the research enterprise, including among other issues training programs and funding organizations, must also make modifications to deal with cultural sensitivity.

Individual Factors

Cultural Competency

At the individual level much work has been done concerning the overall issue of cultural diversity and more specifically the issue of cultural sensitivity. Tello (1985), Cross (1988), Cardenas (1989), and Orlandi (1992) refer to this as cultural competency. While varying slightly, these authors view competency as occurring in stages, with simple awareness of cultural differences being a necessary first step. The second stage is self-assessment, that is, the awareness of one's own cultural values. It is thought that people must understand their own culture (i.e., recognize that they have a cultural lens) before they can be sensitive to other cultures. The third stage is an understanding of the dynamics that may occur when members of different cultures interact. These three steps enable individuals to adapt to diversity and to adjust

professional skills to fit within the cultural context of the ethnic community. Green (1982) clarifies this process by pointing out that to be culturally competent means to conduct one's professional work in a way that is congruent with the behaviors and expectations that members of a cultural group recognize as appropriate among themselves. He states that it does not mean that researchers can conduct themselves "as though" they are a member of the group. Rather, they can engage the community on something other than their own terms and demonstrate acceptance of cultural differences openly, without condescension.

The Meaning of Culture, Cultural Change, and Cultural Sensitivity. To expand upon this issue, the term culture must be given substance. Lum (1986) summarizes many ideas concerning culture. He indicates that culture deals with the social heritage of humans. Culture is the way of life of a society. The prescribed ways of behaving, beliefs, values, and skills are various aspects of culture. It is the sum total of life patterns passed on from one generation to the next within a group of people. Culture is a code that guides interpretation of behavior. Orlandi (1992, p. vi) in a recent OSAP monograph puts it this way, "Culture is the shared values, norms, traditions, customs, arts, history, folklore, and institutions of a group of people."

From the above it is clear that culture is not static but is constantly being altered. Indeed, cultures can be viewed as living, evolving systems where over time some cultural traits remain, some change, and others are discarded (Attneave, 1989). A common, but limited, view of cultural change is that it occurs along a single continuum from "traditional" to "modern." Drawing attention to this perspective is important because it is both common and it can lead to the devaluing of the culture of the people under study (Beauvais, 1989). Inherent in this approach to cultural change is the idea that people move from the old to the new; and, while in transit, they are confused, experiencing stress, and in general are not able to function competently. Something of the old is lost when one embraces the new. These themes of loss, confusion, and stress emphasize the negative aspects of cultural change and represent a limited view. This approach can contribute to a lack of cultural sensitivity.

An alternative to this linear view of cultural change is the concept of biculturalism. Biculturalism is the ability to function effectively in the mainstream culture and yet maintain positive and significant cultural connections to the ethnic community. Oetting (1989) refers to this approach as orthogonal ethnicity. This approach draws attention to the idea that people are capable of identifying independently with more than one culture. McFee (1968) describes how some Indians in his research shifted their frame of reference when interacting with Whites and then shifted back again when dealing with members of their Blackfeet community. He formed the metaphor of "150% man." While possibly mystifying the process, this metaphor points out that, for his respondents, cultural change was not a journey of loss but rather one of gain. The bicultural approach introduces the possibility of increased cultural sensitivity because it allows equal treatment and co-existence of cultures rather than requiring the movement from "traditional" to "modern."

To be culturally sensitive, a researcher needs to gain an understanding of the meaning of the institutions, values, religious ideals, habits of thinking, artistic expressions, and patterns of social and interpersonal relationships that influence the lives of the members of the community in which the research is to take place. Clearly this is not a simple task. How well non-members of a culture can actually accomplish this is certainly questionable. However, the alternative of ignoring culture in working with ethnic populations relegates the research endeavor to one of little importance to these communities.

Typology of Values. A useful starting point in thinking about cultural sensitivity is to focus on values. Some authors have developed typologies that compare dominant cultural and other, primarily ethnic cultural values. Randall-David (1989) compares common values of "Anglo and Other Ethnocultural Groups." For example, she shows that Anglos value mastery over nature, doing activity, and individualism while other ethnocultural groups value harmony with nature, being, and group welfare. It is important to note that approaches such as this most often treat culture as a dichotomy, comparing Anglo values to the values of all other cultural groups. Although there may indeed be

many similarities between broad cultural groups, these typologies carry the risk of lumping together all Anglo and all non-Anglo cultures and attempting to treat them as if there are only two large cultural groups. The limitation of this is apparent when one considers the multitude of cultures within even one of the ethnic populations. For example, the Hispanic/Latino culture consists of people from a wide range of geographical and national backgrounds. The same can be said of the Asian and African American populations. Even the American Indian population, although often thought of as one general culture, consists of over 512 federally recognized and another 365 state-recognized groups (Fleming, 1992).

This approach to understanding cultures also carries with it the danger of the ecological fallacy. That is, what may be true for the larger group may not be true for the individual group member. Even if precise values and cultural traits can be specified for each division and subdivision of an ethnic group, they may not be applicable to individual members of the group. In essence, the risk inherent in the use of frameworks that specify particular cultural values/traits is that stereotypes may be formed which are then applied to all members of the culture under consideration.

So why use these frameworks at all? Taking these cautions and limitations into account, this dichotomous approach remains useful as an overview in helping to sort out possible areas of cultural difference. It draws attention to the idea of differences and gives direction to researchers in their quest to understand the meaning of culture for themselves and for their target populations. Use of such frameworks can assist researchers in working through the first two steps of cultural competency, those of acquiring an awareness of cultural differences and becoming aware of one's own culture. In other words, this approach is a reasonable starting point for more indepth inquiry into the issue of cultural sensitivity.

After this starting point of examining differences in cultural values, what comes next? Given the range of cultures that exist and the amount and kind of knowledge that is necessary to carry out research in a way that is compatible with the culture of the

study population, how can researchers attain an advanced level of cultural sensitivity?

Get Involved with the Community. The simple answer is that the researchers must become involved with the target community in a way that allows for the acquisition of meaningful cultural knowledge. Since the culture of each ethnic group and perhaps each community varies, there is no substitute for direct and extended involvement with the community of interest. This involvement does not occur in a vacuum; rather, it happens as part of the research process. Frameworks such as that presented by Randall-David (1989) can start the process of acquiring an awareness of cultural issues that facilitates entry into ethnic communities, while involvement with the community is necessary to enhance cultural sensitivity.

Institutional Factors

But how likely is it that individual researchers, even given a strong desire to attain culturally sensitive research skills, will have the time and resources to accomplish the process described above? This is where the larger research undertakings of training and funding come into play. Once new researchers complete their formal education and enter the field, it will be difficult for them to devote the resources necessary to focus on cultural issues.

Research Training

The initial process of acquiring an awareness of cultural issues must be incorporated into the basic training of researchers who aspire to conduct work in ethnic communities. University-based programs need to include an examination of cultural issues in programs utilized to train researchers. It is probably unrealistic to expect coverage of cultural material in all research courses; however, the alternative of no coverage is not acceptable. Introduction research method courses could be modified to incorporate information on alternative world views, and frameworks comparing different value structures could be discussed with special focus on the implications for cross-cultural research. In addition, a particularly promising alternative would be the inclu-

sion of some type of cross-cultural research internship. By themselves these steps would not produce culturally sensitive researchers; however, this approach to training would be an important first step. The challenge here is to design programs in a way that incorporates in-depth coverage of cultural issues, while not taking away from the research methods and statistical related material that are necessary to produce competent researchers.

Research Funding

At the funding stage, individual researchers rely primarily on government agencies and foundations for resources to carry out research projects. Research grants focused on ethnic communities should support the extra time and energy necessary to carry out appropriate cross-cultural work. Besides technical merit, proposals that involve research with ethnic groups should be evaluated on the cross-cultural experience of the research team, the demonstration of knowledge specific to the target culture, the use of culturally specific interventions/instrumentation, and the utilization of cultural consultants. If an important project is proposed that lacks some of these factors, funding should be set at a level that provides adequate resources and time to address these issues. When funding sources deal with cross-cultural research in this manner, culturally sensitive research will become a possibility.

Guidelines for Action

Attention to the individual and structural issues described above are important in the end to producing more culturally sensitive research. In addition, there are culturally sensitive guidelines or operating principles that are currently available. Some of these are as follows: (1) the community's ideas and the researcher's ideas are both important—the definition of problems and the goals of the research should involve the community in a meaningful way; (2) community leaders may not know what the community's needs are—a needs assessment should be conducted; and (3) community members may not understand the "research

culture" or the needs of the research process—explanation of these issues will need to take place, and it is essential that it be accomplished respectfully.

Obtaining Community Support

In conducting research in American Indian communities, a first step is to describe the intent, nature, and benefits of a possible project before the governing body (Beauvais & Trimble, 1992). On reservations, identification of the governing body is clear-cut and would ordinarily be the Tribal Council. Urban Indian communities do not have a governing body; however, for research purposes, a parallel step might mean meeting with a group composed of representatives from the major Indian organizations. In addition, a community meeting open to all Indian people could be utilized to explain the purpose, costs, and benefits of the research. It is important to note that the purpose of such meetings is both to show respect for the community by informing them about the proposed research and, equally as important, to obtain feedback from the community.

Research with other ethnic communities would likely follow this approach of meeting with representatives of organizations and conducting community meetings. The point of this process is that an important part of being culturally sensitive is to have the sanction of the community. Without it, whether formal or informal, researchers will always be seen as outsiders and hence be frustrated in further attempts to establish credibility.

One example is a research project I conducted in an urban Indian community. The purpose was to examine barriers encountered by American Indians in their use of human services agencies. In designing the study, I proposed that a sample of Indian people be interviewed concerning their experiences in attempting to obtain services. Following the procedures outlined above, I presented this idea to a group of Indian people, including several formal and informal leaders from the community. The response was that "Indians have been studied enough! If you want to find out about agency barriers, go talk to the agencies." Thus, sanction for the original proposal was not obtained from this community group. I followed their advice and modified the

study to begin by interviewing a sample of agencies used as referral sources by the major Indian community agency. Endorsement for this new approach was obtained from the community group. The project was successful, and eventually many Indian people provided input into the study. The key to carrying out this research was obtaining community support by asking for and accepting guidance from the community.

Involving the Community

In addition to obtaining community support, culturally sensitive research involves the community in the actual research process from start to finish (Davidson, 1988). The research team should include the technical researchers, a broadly constituted steering committee, and local research colleagues (Mohatt, 1989). To every extent possible, ethnic community members should be employed as part of the research team. This team should then meet as a group throughout the process of the research to determine and monitor the specifics of implementation, explanations to the community, and reporting of results.

While not addressing all ethnic communities, Shore (1989) in his "Essentials for Psychiatric Research with American Indians and Alaska Natives" outlined many steps necessary for culturally sensitive work in these communities. The elements of his schema as modified to reflect general research with all ethnic cultures are:

1. Planning should begin with collaboration between the researcher and the community.
2. The focus of the research should be compatible with local priorities.
3. The research design and the selection of a particular methodology should consider the relevance of the outcome for use by the community.
4. The methodology should be realistically conceived and limited in its focus and goals. It should be a practical method for field application in a transcultural setting.
5. The research should be implemented in a local community partnership with an attempt to employ community members as staff whenever possible.

6. An agreement should involve sharing the research findings with the local community in a way that maximizes relevance for program planning.
7. Human rights must be protected. (i.e., informed consents used)
8. Community confidentiality must be protected.

Conclusion

It is through conscious and sustained attention to issues of cultural sensitivity that we can serve ethnic communities. We must first seek to understand the historical and contemporary nature of the cultures with whom we work. With this initial cultural understanding, we can then concentrate on forming research partnerships with ethnic communities. It is this commitment to working in partnership that is the measure of culturally sensitive research. The strategy presented in this paper—that is, focusing on individual and institutional factors that lead to a research partnership—creates the possibility that we as researchers can contribute lasting value to ethnic communities.

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The Relevancy of Cultural Sensitivity in Alcohol Prevention Research in Ethnic/Racial Communities

Robert G. Robinson

Introduction

Drs. Jean Gilbert and James Moran have very ably provided a framework for understanding the complex meaning of cultural sensitivity. In addition, they have also made clear that a prerequisite for cultural sensitivity is a basic respect for the social context of defined populations. Culture expresses the reality of groups. It is learned through processes of language and interactions and reinforced through socialization. Culture is dynamic, ever changing, ever responsive, and, most important, is continuously integrative and uniquely expressive of itself. Similar to water which constantly seeks its own level, the culture of a people transforms and reshapes itself, in the words of Dr. Gilbert, "by cumulative adaption to changed circumstances." Culture expresses the way of life of a people and mirrors its norms, beliefs, values, and skills. It acts, according to Dr. Moran, as "a code that guides the interpretation of behavior." In essence, culture is a lens through which reality is experienced and perceived. We are reminded that all reality is socially constructed, and that there are as many realities as there are historically bound groups.

The historical nature of culture could have received more attention. The term "historically bound groups" suggests that there are as many cultures in the world as there are such groups. The term "bound" does not imply bondage or entrapment. Indeed, culture can be liberating as well as stifling to the human spirit. Historically bound means simply that each culture is determined by its unique historical path. It cannot be defined independently of that path, and therefore it cannot be understood without appreciating its particular historical context. Each author addresses in depth the need for cultural sensitivity if researchers are to do good research. Each author explains how difficult is the task to be culturally sensitive. However, part of that difficulty is the refusal to come to terms with history. It is a difficulty that the authors do not fully address; despite their able response to the need for researchers to respect and understand the relevance of the unique historical underpinnings of a group's current social reality. It may be a task too comprehensive for the modern researcher.

History is particularly important when the relationship between the group represented by the researcher is not on an equal footing with the group being researched. This is critical when the historical context of the group being researched is intimately entwined with the group of the researcher. For example, it is often said that a cultural characteristic of the people of the United States is that they are ahistorical. In other words, the events of today can be explained by the sum total of four, eight, or 20 years. Indeed, the numerical unit chosen may be more a function of one's political party than of historical awareness. Thus, we can be subjected to such simplistic analyses as that the anger that followed the Rodney King verdict is rooted in late 20th century social policy rather than the context of slavery and racism. This exemplifies an ahistorical analysis.

It is typically impossible, or at least relentlessly difficult, for the average White American to focus on the historical legacy of slavery. Yet, if an in-depth discussion with an African American is pursued, he or she will demonstrate an understanding of this legacy. If you engage an American Indian, the discussion will lead to the topic of their attempted genocide. Discussions with

Chicanos may very well lead to the topic of the United States appropriation of Mexican land. The fact that for other groups the historical path is clouded because we have not been taught the truth does not invalidate the importance of understanding history.

Researchers who are insufficiently self-critical of their own lack of historical knowledge of a people are particularly at risk for being insensitive. Indeed, they will underestimate the community, and there will certainly be a representative present who has a grasp of the historical legacy. Appreciation of historical context by researchers will be relevant even in circumstances when the research question being studied is not firmly rooted in the historical context of the community. The importance of cultural sensitivity is only partially determined by the nature of the problem being studied. Its importance also derives from the fact that cultural sensitivity is heightened by the awareness that history shapes the differences researchers seek to analyze in explaining cause and effect. Regardless of the problem, "the level of appreciation" for historical context will predict the researcher's capacity to be culturally sensitive.

One barrier to cultural sensitivity is the difficulty of overcoming the roles of oppressor and oppressed. The authors pose other barriers. Certainly major barriers are the abstract nature of the elements of culture and their immense variability across cultural groups. Unlike material manifestations of culture—such as dress, food, and levels of technology—values, beliefs, and perceptions are not visible, more precisely, they are abstractions. Indeed, these abstractions are the primary elements that shape the normative context of behavior (i.e., alcohol use or abuse). If these abstract elements cannot be experienced, then they cannot be integrated into the conceptual framework of the study. Or, if they are incompletely understood, they are poorly used in the research process. Again, the danger emerges when the researcher is ignorant of his/her limitations. Without self-criticism there is no corrective process. Without humility there is no true respect for the need to be self-critical.

Lack of cultural sensitivity is further exacerbated by divergent agendas of the researcher and the community. Although

neither exists in its ideal form, the researcher maintains an objective relationship to the community and the community is absorbed in the subjective experience of the phenomena being researched. The needs of both the researcher and the community are different, the stakes of each are different, and the rewards, while not mutually exclusive, are certainly not interdependent. Dr. Moran reminds us that this is particularly problematic in ethnic/racial communities, given the historical context of distrust and alienation directed to persons perceived as outsiders. It is likely that researchers who are part of the communities being researched will experience the same rewards shared by the community. When this occurs, interdependency is enhanced. This shared experience may also be experienced by outside researchers. If researchers, regardless of origin, could objectify this experience, then they would have a measure of cultural sensitivity.

How then are these barriers overcome? How does the researcher achieve cultural sensitivity? First, there is the realization that culturally sensitive research is a process, not a product. It is the way one engages the community. It is the rules or principles governing the research process that determine the degree of cultural sensitivity. Dr. Gilbert quotes Rogler and states it is "a continuing and open-ended series of substantive and methodological insertions and adaption designed to mesh the process of inquiry with the cultural characteristics of the group being studied." In more practical terms, Dr. Moran suggests that the researcher must become involved with the community in a direct and extended manner, involve the community and ideally allow the research goals to evolve from the community, implement a needs assessment, and educate the community regarding the characteristics and perhaps even the requirements of the research process. Other suggestions are to hold community meetings and follow their advice, involve the community from start to finish, and employ members of the community as part of the team.

Dr. Moran poses a concept of cultural competency. This concept is very similar to the steps, suggested by Dr. Gilbert, to be taken by the researcher on the path to cultural sensitivity. The researcher must be aware of cultural differences or at least admit

how little he/she knows. The researcher must be open to self-assessment or at least an examination of his/her assumptions of the culture with those of the group being studied. Indeed, direct immersion in the community is again advised as the best corrective for testing one's assumptions.

The final threshold of cultural competency is for researchers to adjust their professional skills to fit the cultural context of the ethnic/racial community or, ideally, conduct themselves as though they were a member of the community. The research itself must rely on group-specific baseline data, target the informal sector of the community where most of the targeted behavior occurs, and relate to the influence and power structures in the community, particularly when mobilization for policy-related changes is needed. The result of these changes and adaptations is research that will be more relevant to the community, more descriptive of cultural differences, and more likely to explain program effectiveness across cultural groups or suggest when specific tailoring of programs is needed.

Summary Comments

The following are summary comments of selected analyses posed by the authors, as well as independent assessments.

1. Each author discusses in depth the need for researchers to involve themselves intimately with the community. However, the amount of time being provided to researchers to do their work is being shortened, not lengthened. Where will the time come from for all of this intimacy and direct immersion? The current environment may very well result in an increase in research that is less culturally sensitive.
2. Biculturalism, or the ability to function adequately in both worlds, is viewed as a positive extension of acculturation. The example in Dr. Moran's text is of an American Indian who is described as "150% man." The author admits that this concept potentially mystifies the process of becoming bicultural. One is reminded of the descriptions used for successful African Americans who were considered "exceptional." Perhaps a more "sensitive" appraisal views this person as just a man,

and views those who are unable to achieve similar levels of sensitivity as deficient and in need of improvement. Admittedly, Dr. Moran is using the concept to suggest that progress is not linear but a synthesis of multiple experiences, including divergent cultures.

3. There is a distinction between researchers who lack cultural sensitivity in contrast to a research environment that is inherently insensitive because it reflects a particular, usually a dominant, culture. The solution to the former is that we need better researchers. The solution to the latter is that we need structural changes in the way researchers are educated, research priorities defined, and research projects funded. The recommendations were necessarily prescriptive and lacked power because they were not rooted in empowerment strategies that might lead to real change. This is less a criticism of the authors than a suggestion for the work that needs to occur.
4. The inherent humanism in cultural sensitivity should not be used to disguise the need to address issues of affirmative action, or prescribe a research agenda that is responsive to the critical need for more researchers of color in principal investigator and related leadership roles.
5. Little attention was given to research goals that targeted structural or policy-related changes regarding alcohol use or abuse. Prevention research was often defined as targeting behavioral change. The evaluation goal was to determine effectiveness in achieving behavioral change. Ironically, cultural sensitivity suggests, in communities of color, that researchers target the environment rather than the individual. If outcome priorities were reordered, then other criteria for evaluating the efficacy of research projects would need to be established (i.e., capacity development of organizations, increased awareness of gatekeepers, cross-substance abuse coalitions, legislative initiatives). The communities we are discussing at this workshop require more than sensitivity; they require advocacy.
6. Research that targets communities of color must include community development components. The criteria for evaluating research should depend on more than rigor as defined by sample size, control groups, or tests of significance. Other

criteria are how effectively communities can initiate, develop, and evaluate related programs after the research. Another criterion is whether researchers of the community were trained during the process.

Two notes of caution are offered. First, there is the danger in viewing change as a zero-sum game. Including community development criteria is seen as a loss for other research priorities. Second, the funding criteria may be altered and add to the difficulty of getting research funded, or at least change the rules in a way that benefits competitors. The first concern should be modified by appreciating that no one paradigm offers a total solution. It is critical to make room for alternative models to help achieve a broader, hopefully improved, assessment of complex problems. Regarding the second concern, if criteria are presented to benefit other researchers such as African American, American Indian, Hispanic, or Asian researchers, it could be cost effective when they provide assessments that result in better interventions.

7. The problem of communities that perceive evaluation as an invasion can be solved if evaluation is implemented according to principles of cooperation, collaboration, and technical assistance by which the program is improved rather than only measured. Of course, this will depend on the stage of the program and whether it has ever been evaluated. More important, it suggests that the research environment at large can be measured by how much of its resources targets "pure" evaluation vs. evaluation that is instructive and corrective. This too can be built into the criteria for funding.
8. Some attention should be given to the categorical nature of alcohol- and drug-related research. From the perspective of community empowerment, the targeting of separate social problems, separate coalitions, and separate components of community infrastructure contributes to fragmentation. This is inherently disempowering and contrary to principles of community development.
9. The solutions suggested for cultural sensitivity approximate recipes for behavior changes. They each require that the

- researcher make a credible investment in the time he/she spends with the community under investigation. In fact, most successful researchers are engaged in multiple projects with little time to spend in the field. They work through subordinates who are themselves overworked. Unless solutions are posed that will address the research environment, then researchers will have little inspiration to change behavior.
10. Culturally sensitive research will be best done by representatives of the culture. Unless affirmative action is supported in educational programs, NIH, and related research centers, then the goal to increase the amount of culturally sensitive research will only be minimally met. This principle does not suggest that only researchers of a community should do the research. Rather, the statement describes a basic correlation. An increase in culturally sensitive research will occur according to the number of researchers from the community engaged in the research. Ideally, they should be the principal investigators of the projects.
 11. Community development is a criterion that can potentially affect several research-related outcomes. (1) It will influence the relationship between the research team and the community. (2) It will influence the makeup of the research team. (3) It will influence measures of efficacy and effectiveness in evaluating the results of the research. (4) If community development is also perceived as a concept that influences the development of researchers as well as communities, it will impact research priorities. For example, material and program development-related research is more conducive to developing and preparing emergent researchers (presumably from communities of color) in their early careers. It is not realistic to expect an increase in researchers from communities of color if funding primarily targets large trials or demonstration projects that typically require experienced leadership (presumably from the dominant community). (5) Another benefit of directing funding to "early phase" research is that the qualitative methods usually emphasized in these designs and protocols facilitate outreach and development of community leadership (i.e., focus groups can be

used to identify lay leadership). This is precisely the infrastructure needed when community-based demonstration projects are implemented. Finally, what is suggested is that the ultimate effectiveness of intervention research will be enhanced if community development is integrated into each research phase.

2000-2001

Part III

Conceptual and Methodological Issues in Community-Based Prevention Research

5

Alternative Models of Community Prevention Research in Ethnically and Culturally Diverse Communities

Mary Ann Pentz

Introduction

Several national surveys have shown that, overall, adult and adolescent drug use is declining in the United States (Johnston, et al., 1989; Goldstein and Kalant, 1990). There are some exceptions. Most notably, the prevalence rate of daily crack use among adults has not declined; nor has the prevalence rate of heavy alcohol use among adolescents and college students declined (Johnston, et al., 1989; Goldstein and Kalant, 1990). Problems associated with alcohol and other drug abuse, particularly accidental and violent deaths, and crime, have also not declined (Goldstein and Kalant, 1990).

Changes in drug use have been attributed to national mass media attention to the drug abuse problem, establishment of school prevention programs, and, most recently, efforts to organize communities for alcohol and other drug abuse prevention (Pentz and Valente, 1993). Systematic evaluation of the independent effects of each on community drug use is difficult, since

all three "movements" have occurred in rapid succession or simultaneously since the mid-1980's. However, quasi-experimental comparisons of the outcomes rendered from school-based prevention programs (the most common interventions available for drug abuse prevention) with community-based heart disease and drug abuse prevention programs suggest that the latter may produce relatively larger and longer lasting declines in drug use (Kottke, et al., 1985; Vartiaian, et al., 1990; Pentz, in press). One obvious explanation for the difference is a dose-response effect: community interventions typically expose individuals to more prevention program channels and messages more of the time compared to limited, single-channel programs such as school educational programs. However, community interventions are not simply a compilation of multiple program components. While difficult to show empirically, the cumulative effect of these program components may be due as much to the ability of community leaders to organize the planning, packaging, and delivery of intervention to the community population as to the effect of the program components themselves.

Is there a single recommended standard, model, or protocol for communities to organize for prevention? This is highly doubtful, for unlike schools, which are equipped for and expect standardized teacher training for program delivery, standardized program materials, and program delivery schedules, communities are more complex, representing diverse interactions of person, situation, environment, interests, constituents, and needs. Some variations in these interactions reflect specific person, situation, and environment factors indicative of ethnic/racial populations in the United States.

The purpose of this paper is to consider basic parameters in the conduct of community prevention research, with special—albeit not limited—application to alcohol and other drug abuse prevention research in different ethnic/racial communities. Classifying communities according to these parameters suggests an initial "blueprint" model for community prevention research, with several choice points that enable the mapping of specific community needs and characteristics onto the model, including the specific needs represented by ethnic/racial communities.

First, an integrated theoretical perspective is applied to the understanding of community prevention research. Second, general factors in community prevention research model building are described. Third, specific choice points representing ethnic/racial community considerations in the model are discussed relative to four hypothetical case examples. Fourth, an example of the model applied to large urban centers that encompass multiple communities is briefly described, the Midwestern Prevention Project for adolescent alcohol and other drug abuse prevention. Finally, gaps in community prevention research are identified which represent particularly timely directions for future research in the area of alcohol and other drug abuse in the United States.

An Integrated Theoretical Perspective

Community organization for prevention, and conceptualization of community prevention research, can be expressed as the interaction of person \times situation \times environment level factors that are bounded by a community (Perry and Jessor, 1985; Pentz, et al., 1986). Person-level factors are intra-individual variables that predict which community leaders will organize and whether they will organize effectively; which individuals might be selected for prevention program implementation and how well they will implement programs; and which consumers are likely to benefit most from intervention. In alcohol and other drug abuse prevention, nonsmoking status and previous civic service involvement of community leaders are associated with active participation in community organization for drug abuse prevention; younger age and acceptance of interactive teaching methods are associated with better prevention program implementation among teachers; and active participation in program discussion, homework activities, and seeking out parent support for drug abuse prevention are associated with greater effects on program-mediating prevention skills among adolescents (Pentz and Valente, 1993).

Situation-level factors involve inter-individual variables. Regular communication among leaders of different community

agencies and centrality of these communications, supportive communication between teachers and principals, and positive parent-child communication about drug abuse prevention are associated with increased community organization and decreased drug use for community leaders, program implementors, and parents and adolescents respectively (Pentz and Valente, 1993). Finally, environment-level factors involve organizational and system-level variables. Active representation of businesses, reallocating existing resources, and concise, well-disseminated prevention-oriented policies are associated with greater initial and sustained community organization for drug abuse prevention, more positive mass media coverage of community organization, and decreased community acceptance and social norms for drug use (Pentz and Valente, 1993).

Two points are central to developing an understanding of the complexities involved in applying an integrated person x situation x environment perspective to community prevention research. The first is identifying what constitutes a "community." Sarason (1974) and others have emphasized that a community can be identified on the basis of geographic, social/sociocultural, and psychological boundaries; all three boundaries should be considered in developing and tailoring of preventive interventions to the specific needs and resources of the community (Pentz, et al., 1986). Second, the integrated person x situation x environment theoretical perspective is built on separate theories or models that, when used to develop the content, structure, and process of preventive interventions, have shown the most promise for producing health behavior change in individuals and communities. Most prominent among these are the following.

At the person-level, Bandura's (1977) social learning theory represents a major influence on the development of preventive interventions that have shown significant changes in reducing adolescent health-compromising behaviors, including alcohol and other drug use, unprotected sex, and dietary intake (Perry and Jessor, 1985). According to this theory, community leaders, parents, and student peer leaders in a community must serve as credible models of health-promoting behavior. The immediate implication of this theory for community organization for alcohol

and other drug use prevention is that community leaders should "practice what they preach."

At the situation-level, social support theory and theories about social normative expectations can be translated to mechanisms by which community leaders organize themselves, represent and support the whole community as a constituency, and use the mass media to change perceived and actual social norms for alcohol, drug use, and other health-compromising behavior (Barrera, 1986; Pentz, et al.). According to social support theory, for example, community leaders can develop a community organization for prevention and tasks of that organization are structured along the lines of physical, fiscal, or emotional needs of a community. Achievement of goals and completion of tasks are then measured as community resident satisfaction.

At the environment-level, organization development models and social structure theories have contributed to the understanding of the structure and process of community organization and to the patterns of communication between community agencies and community leaders (Warren, 1967; White, et al., 1976; Katz and Kahn, 1978; Biklen, 1983). For example, Katz and Kahn posited that voluntary community organizations operate based on four parameters: (1) resources and resource acquisition, (2) a defined organizational structure (e.g., top down vs. bottom up, lateral vs. hierarchical, on a continuum from participative to autocratic leadership), (3) specific production activities and assignment of their responsibility to individuals or groups within the community organization, and (4) identified outputs or products, including timeliness for completion (Katz and Kahn, 1978).

The block model concept and methodology developed in sociology is useful in identifying sets of community leaders who are most likely to work together effectively, as well as subunits or blocks of community residents who are most likely to participate in and support local community organization (White, et al., 1976). Interorganizational field theories add to the block model concept by positing that a community organizes for maximizing and broadcasting specific values up to a certain threshold (Warren, 1967). Community organization for drug abuse *prevention*, for example, might draw on community leader, community

agency, and mass media resources to the extent those resources for drug abuse *treatments* are not jeopardized. Also contributing to an integrated theoretical perspective at the environment-level is diffusion of innovation theory and theories related to changing perceived and actual social norms in a community (Pentz, et al., 1986; Pentz and Valente, 1993). According to diffusion theory, community leaders can strategize about how to promote adoption of a preventive intervention between themselves and community resident trendsetters; early adoption by these individuals up to 10% or 11% of the community population will subsequently diffuse throughout the remainder of the community. According to social normative expectation theories, feeding back the results of research to a community will correct misperceptions about the prevalence rates and social norms for health-compromising behavior and mediate changes in subsequent health behavior in that community.

A General Model of Community Prevention Research

To be useful to community leaders as well as to researchers, a model of community prevention research should specify the structure, process, implementation, maintenance, and outcomes of community organization. Each can be expressed as a phase in community organization; each phase is then expressed as a set of constructs with manifest indicators; each construct within a phase gains prominence in sequence before the next phase is initiated. A simpler version of this model was developed for a large multi community trial for adolescent drug abuse prevention, the Midwestern Prevention Project (see description below and model description in Pentz and Valente, 1993). This 10-step model to community organization begins with identification of the target community and population and ends with a continuous loop mechanism for maintaining community organization and prevention program implementation. Each step is evaluated for its completion; the model presupposes that effective community organization cannot occur until all steps are completed.

The expanded model presented herein allows for more flexible choices at each step to accommodate the special needs of

ethnic/racial communities, includes evaluation of initiating events as well as long-term community health priorities to provide direction respectively to initial community organization and maintenance of community organization, and specifies individual variables for each construct or step of organization. The model is shown in figure 5-1.

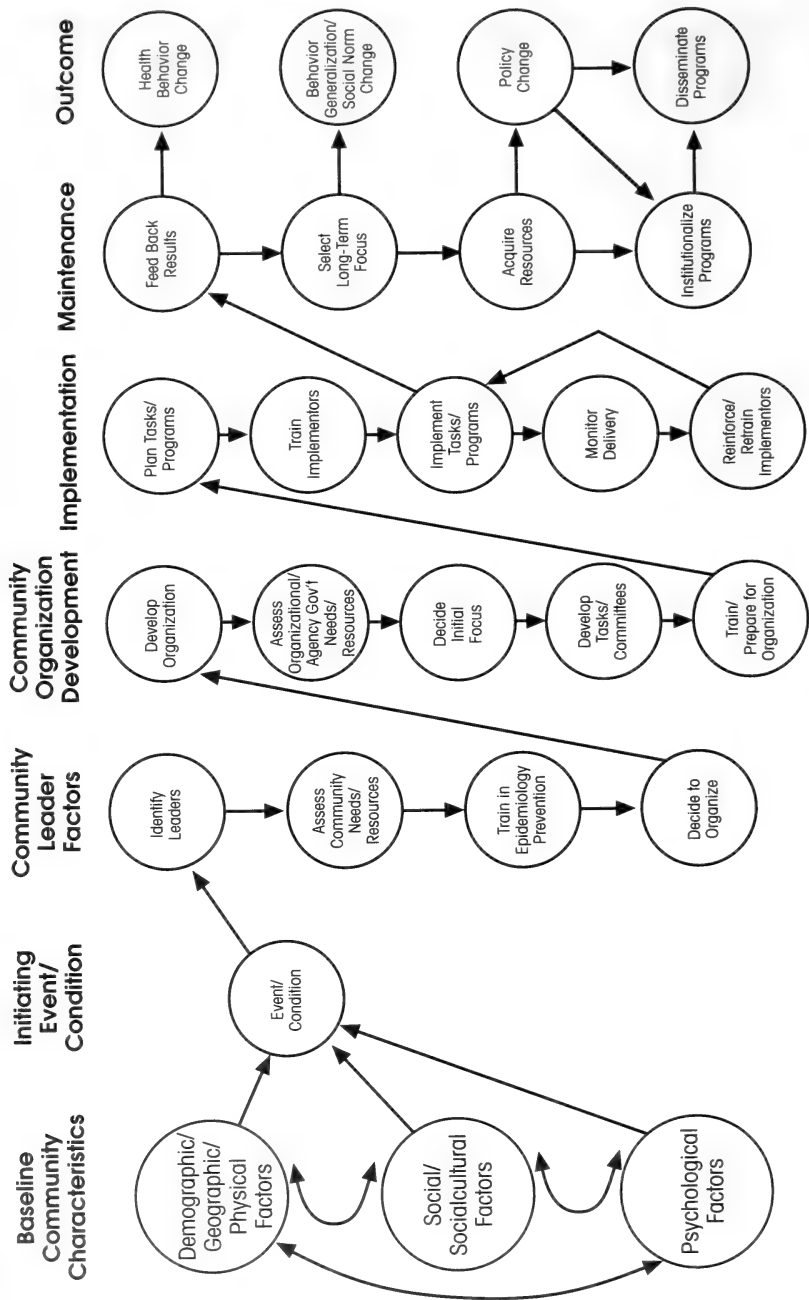
Baseline Community Characteristics

Baseline community characteristics are entered first in sequence in the model. These characteristics are represented by the same physical/demographic, social, and psychological constructs used to define boundaries of communities, as suggested by Sarason (1974) and Wandersman and Giamartino (1980). Physical characteristics include the physical condition of the community, size, residential stability, ethnic/racial makeup, income, home/business ownership, urbanicity, and population density, as well as the physical resource "plant" represented by the number of financial, informational, and support networks among existing organizations within the community (Galaskiewicz, 1979; Perkins, et al., 1990). Social characteristics include the centrality of communications among existing organizations; the level of support or conflict between organizations, schools, mass media, and local government; positive community acceptance (versus passive tolerance) of new and existing ethnic/racial groups; acculturation of ethnic/racial groups to the community (versus general societal acculturation); and sense of affiliation among ethnic/racial groups. Psychological factors include the perceived and actual empowerment of the community, existing organizations within the community, and individuals to effect health behavior change; the perceived and actual readiness of the community to participate in such change; and the level of community "upset" or intolerance for existing conditions.

Initiating Events or Conditions

The initiating event(s) or conditions that serve as catalysts to community organization are entered second in the model. Event(s) can represent negative or positive community life events to which a community "reacts" by initiating the process of com-

Figure 5-1



munity organization around the event topic. A negative community life event, such as a tragic drunk-driving death of an adolescent on the night of graduation, increases community awareness of youth alcohol problems and can escalate to the level of a perceived community crisis if all population groups in the community have directly experienced a similar type of event or have been mobilized by the local mass media to empathize with the affected group. A positive community life event, for example, a civic service award to and broad mass media coverage of a youth group that has developed an innovative approach to community outreach services, is a much rarer stimulus or catalyst to community organization for prevention. Why? The answer probably lies in the complex sets of stimuli in today's high-technology society that vie for the attention of individuals within a community on a day-to-day basis. Accumulated on a community level, such stimuli or events may come to the prolonged attention of community leaders only if they are sufficiently noxious to threaten all residents' well-being; otherwise, daily life proceeds more or less according to the status quo that even dissatisfied residents are sluggish to change (Sarason, 1974). A recent, horrifying example of a threatening community life event that has spurred community organization for rebuilding but still may be delayed by sluggishness of the status quo is the recent Los Angeles riots and fires in reaction to the Rodney King beating.

Chronic adverse conditions in a community may also serve as a catalyst to community organization. In this case, no particular event triggers organization; community residents and leaders have already had preliminary discussions about community needs; the discussions evolve into community organization. Perkins et al. (1990) have evaluated a model of participation in community block associations that showed an association between chronically poor physical conditions in a neighborhood and subsequent participation among residents who expressed an affiliation with the neighborhood.

Community Leader Identification and Preparation

The third phase in the model is identification of community leaders who will organize the community for prevention, and the

process that leaders undergo to prepare for formal community organization. Leaders may be leaders of existing formal organizations in the community, for example, directors of local health agencies, youth agencies, churches, parent groups, schools. If the community has had a history of failure with formal organizations, however, residents may decide to nominate "grassroots" leaders from the resident population who are known and respected by residents but who have served in no formal leadership capacity before organization. Several general criteria have been used in community studies to identify leaders for community organization. These include positive modeling of the target health behavior, prior history of civic service, recognized "gate-keeping" function in the community, and commitment to a minimum two-year term (Vartiaian, et al., 1990; Pentz and Valente, 1993). In community organization for prevention programs with youth, criteria for selection also include whether leaders collectively cross-cut all or most of community functional sectors, and services for youth (Vartiaian, et al., 1990; Pentz and Valente, 1993). Sectors and services include mass media, education, business, worksite, health/mental health/medical, treatment and prevention agencies, youth and social services, youth recreational services, religious organizations, and relevant ethnic/racial organizations. Virtually no research exists on whether self- or other-nomination is more effective in generating a group of community leaders who can later collaborate. However, some studies have shown that the nomination process is made more efficient by a snowball-sampling method of community leader identification, By which widely known and respected individuals in the community are asked to nominate prospective leader candidates, and those candidates with repeated multiple nominations are approached as leaders (Pentz and Valente, 1993).

Following identification, the proposed model requires that leaders prepare for formal organization in three steps: (1) assessing informally the condition and readiness of the community for organization (initial needs/resources assessment), (2) arranging and participating in initial training in the etiology, epidemiology, prevention, and treatment of the community problem that fostered the initiating event or condition for organizing, and (3)

meeting to formally agree to organize. Training in the second step may be provided by researchers, clinicians, or other experts in the problem area, depending on community leader trust and familiarity with a particular area of expertise, and access to experts as a resource for organization. Formal agreement to organize may expedite the next phase of organization development if it is accompanied by coverage of local mass media that are sympathetic to the problem and supportive of the identified leaders. However, progression to the next phase is likely to be impeded if mass media coverage is negative and/or if community leaders do not believe that they are empowered by residents, local government, or other existing organizations to address the community problem (Florin and Wandersman, 1990).

In reviewing the results of two studies of neighborhood block organizations in racially mixed metropolitan areas, the Neighborhood Participation Project in Nashville and the Block Booster Project in New York City, Florin and Wandersman (1990) concluded that blocks receiving professionally provided training in organization development and materials for suggested programs were significantly less likely to decline in participation after 10-month followup. Pentz and colleagues reported a similar finding from Public Broadcasting System stations to organize community leaders for drug abuse prevention after the viewing of the Chemical People series starting in 1983. Task forces that included a professional in drug abuse prevention as a member and trainer of other members were significantly more likely to be operating after 15-month followup (Pentz and Valente, 1993).

Community Organization Development

The fourth phase in the model is development of the community organization itself. Katz and Kahn (1978) noted that organizing communities effectively to address a particular problem or goal requires initial resources, a structure recognized by leaders and residents, specific production activities, and outputs or outcomes. Prestby and Wandersman (1985) added factors that contribute to organization maintenance as well as development, including the acquisition of other resources, monitoring of implementation, and feedback to the community. Figure 5-1 expands

the model further by including specification of substructures or committees to address individual production activities, specific training to accomplish these activities, and detailed phases of implementation, maintenance, and outcome after initial community organization development.

Initial community organization will vary as a function of individual community differences in baseline characteristics, initiating events or conditions, and community leader factors, particularly community readiness and community and leader perceptions of empowerment. Besides these individual differences, the particular form of organization will vary systematically according to several parameters: resource networks, incentive systems, problem acuteness, problem generalization, and problem approach.

Resource networks include but are not limited to financial support, information/communication, and physical and social support and transportation (Galaskiewicz, 1979; Florin and Wandersman, 1990). Leaders will tend to centralize their communications and new organizational efforts around the sources of these networks. For example, in a small city dominated by an active Chamber of Commerce, any new community organization for drug prevention will probably organize its leadership and goals around acquisition of financial/business support for prevention programs and activities. The structure of organization would likely be top-down, following existing business and administrative structures in the community; since businesses in any community are inextricably linked with local government, local government would be included early in the community organization process.

In contrast, in a disaffected, isolated ethnic/racial community with no indigenous business leaders and a distrust of local government run by Whites, new community organization might mobilize around neighbors who represent an active communication or transportation network. Organization would be from the grassroots level, or bottom-up; local government would be excluded or delayed in involvement until the community organization as a group felt empowered to demand local policy change regarding the community problem. In this latter case, it is con-

ceivable that the grassroots community organization gains the power to mobilize residents' assistance and cooperation in delivering programs, goods, and services, but that the local government has the financial resources. In a situation that might otherwise produce a stalemate, Florin and Wandersman and others suggest a "coproduction" relationship by which the grassroots organization and local government assume joint responsibility for prevention programs and services: the government for timely funding and the organization for quality delivery and dissemination (Florin and Wandersman, 1990).

Incentive systems include material, solidary [sic], and purposive (Clark and Wilson, 1961). The incentives drive initial and maintained interest of community leaders in participating in community organization, as well as the general objectives and goals of the organization. For example, if community leaders and residents perceive correction of a lack of goods, services, and facilities as the major means to improve the community and eliminate the presenting problem, then the organization will be structured to acquire and reinforce participants with materials as an initial focus, with tasks and work committees oriented toward the acquisition of specific types of materials. Organizations will be oriented toward solidary incentive systems if community residents and leaders experience a low sense of affiliation combined with a need to address the threatening community problem collectively and a perception that relationships among leaders will enhance their individual prestige. Purposive organizational development is oriented toward the achievement of concrete, visible tasks, for example, a community cleanup campaign; this type of organization may be short-lived if the task is an end in itself.

Other parameters involve the initiating event or condition. If the problem is acute *and* little is known about its community-specific etiology and epidemiology, community leaders may decide to organize an initial task force to investigate the problem's size and origins before deciding on a course of intervention. A task force is usually mobilized quickly, gives rapid feedback to community leaders and residents about the scope of the problem, and then is disbanded and/or replaced with other, more

permanent structures to plan, deliver, and monitor interventions to address the problem. If the problem is acute *and* specific, the community may organize as a coalition of community leaders or as a formal community organization that is independent of but includes representatives of other existing organizations. The former may have more sanction and support of local government at the outset. A coalition is structured to represent a formal "united front" against the presenting community problem that includes local government representatives as part of its membership and has local policy change as an explicit or implicit goal.

The Center for Substance Abuse Prevention (CSAP) Community Partnership grants require the development of this type of community organization to address local problems of drug abuse control and prevention. Whether the problem is associated with an initiating event or not, if it is chronic and expected to escalate and if community leaders determine at the outset that they are likely to have adequate resources and commitment to effect long-term change, leaders may develop a formal community organization with a structure that is independent of other existing organizations. For example, as part of the Midwestern Prevention Project (MPP) for adolescent drug abuse prevention, Indianapolis community leaders determined in 1987 that they would have long-term commitment from school superintendents and long-term financial support from the business community (through Eli Lilly Endowment, Inc.) to implement and maintain drug abuse educational programs and campaigns in the greater Indianapolis metropolitan area (Pentz and Valente, 1993). Later in the same year community leaders founded Project I-STAR and registered it with the State of Indiana as a nonprofit community organization for drug abuse prevention.

If the community problem is chronic, pervasive, indicative of general adverse conditions in the community, *and* likely to generalize to other problems and events, community leaders may opt for general community development rather than development of a specific task force, coalition, or community organization. Florin and Wandersman (1990) define community development as the "voluntary cooperation and self-help/mutual aid efforts among residents of a particular locale which aim to

improve the physical, social, and economic conditions of the community" (p.45). Unfortunately, voluntary efforts of this type have tended to suffer rapid decline, with a "mortality rate" of 50% or more in the first year (Prestby and Wandersman, 1985). While little systematic research exists on predictors of community development maintenance, suggested factors include low empowerment, sanction, and recognition of the self-help effort by local government and agencies; and a lack of access to business, health, and research professionals who could manage operations, assist in resource acquisition, provide training in prevention or other program implementation, and feedback results of development efforts to the community (Prestby and Wandersman, 1985; Florin and Wandersman, 1990; Perkins, et al., 1990; Pentz and Valente, 1993).

Finally, the development of an effective community organization effort requires operationalizing goals as a series of tasks with definite timeliness for achievement, delegation of tasks to specific individuals or committees that serve as substructures to the larger community organization, and training or preparing individuals or committees in methods to accomplish these tasks. The tasks, and thus substructures, vary according to either the content of the community problem or the end health behavior change target. For example, community heart disease prevention programs aimed primarily at adults, such as the Minnesota, Pawtucket, and North Karelia Projects, established a formal community organization for heart disease prevention as the first step of intervention; subcommittees or sub-task forces within the community organization were structured according to each heart disease risk factor that was expected to serve as the target of a program or campaign, e.g., cigarette smoking vs. diet (Lefebvre, et al., 1987; Bracht, 1988; Puska, et al., 1989). In contrast, a community drug abuse prevention program for adolescents, the Midwestern Prevention Project, delayed development of a community organization for drug abuse prevention until mass media, school, and parent program components had already been implemented and had shown positive results (three years after initial intervention in Kansas City; almost two years after initial intervention in Indianapolis; Pentz, in press). The planned delay in MPP community organization was based on previous studies

which suggested that a *primary* prevention for youth might have to demonstrate initial effects of intervention before a community would provide a long-term commitment to drug abuse prevention (Pentz, in press). Subcommittees were structured according to functions or agencies that served youth in general.

In both the heart studies and the MPP, communities organized as part of a research design, with researchers as partners sharing the responsibility for the design and community organization with community leaders; a formal community organization for prevention was developed with a long-term commitment of at least five years; and business, health, government, and research professionals were active members of the organization from the outset. Because of the research base, training and evaluation were incorporated throughout each phase of community organization, and selection of prevention programs, campaigns, and dissemination strategies was based on sound theory and research. Because of the types of professionals represented, the initial operational structure of community organization was top-down, with gradual incorporation of bottom-up support and feedback as each community organization was institutionalized and ownership shifted entirely to indigenous community leaders. Also, communications were hierarchical and centralized to improve efficiency in decision-making and decrease the probability for misunderstanding or the development of competing interest groups. Local government involvement helped to ensure that long-term tasks and programs would be adopted as a policy change by the community. By comparison, communities that attempt to organize entirely from the bottom up and/or focus too broadly on general community development, with little or no input from researchers, health professionals, and business leaders, may take longer or fail to identify and achieve specific objectives. They may also select interventions based on popularity or easy availability than probable effectiveness, and eventually decline due to a lack of focus or feedback of results (accountability) to the community.

Implementation

Actual implementation of the community organization's work, or "production input," involves at least five measurable steps:

(1) outlining specific tasks or programs to be implemented, with required resources, delegated personnel, and timeliness, (2) identifying and training implementors, whether they are indigenous to the community or a combination of indigenous personnel and outside experts, (3) implementing tasks or programs according to a standardized protocol used for training and agreed upon by the community organization, (4) monitoring, evaluation, and feedback about the quality of implementation, ideally by individuals who are independent of training and implementation and thus are assumed to be more objective and (5) reinforcing and retraining regularly the implementors to maintain their motivation to continue implementation and to cope with personnel turnover in communities. Consistently, research and program evaluation studies have shown that effects of preventive interventions on health behavior are highly dependent on the quality of implementation *as designed* (Pentz, in press). Programs with no training for implementors and either low levels of implementation or extreme deviations from a standardized protocol yield results similar to no-intervention control groups (Pentz, in press).

Maintenance

While program monitoring during the implementation phase involves giving at least periodic feedback to program implementors, use of regular feedback of results of community organization and intervention is critical during the maintenance phase. If feedback is structured for the public in the form of goals attempted and the percentage of each completed, for example, the United Way thermometer showing the amount of funds raised in a community, community residents can see visible progress of community organization on an annual basis. Several community heart disease prevention studies and the MPP have used annual press conferences for this purpose (Bracht, 1988; Pentz and Valente, 1993). Providing a public forum for this feedback prompts mass media representative and community resident questions and ideas about the "next step," i.e., selection of the long-term focus of community organization. The mass media, particularly, can be useful in setting a public agenda to expect this next step, and to empower the organization to implement

long-term prevention and health initiatives (Zimmerman and Rappaport, 1988; Chavis and Wandersman, 1990). Depending on the initiating event and initial focus of organization in the community, potential long-term foci include prevention of problems that is co-morbid with the initial community problem, for example, a long-term AIDS prevention focus that is linked to initial alcohol and drug abuse prevention; prevention of chronic diseases linked to the initial problem, for example, a long-term focus on cancer prevention that is linked to early smoking prevention; or general health promotion that expands an initial focus on nutrition.

Maintenance will also depend on the acquisition of new physical, financial, and social resources to carry out programs that represent the long-term focus of the organization (Prestby and Wandersman, 1985). Resources should continue to be allocated to program monitoring and reinforcement of implementors to ensure quality of implementation after the novelty effects of community organization have worn off (Sarason, 1974). In addition, if dissemination is a long-term focus of community organization—more likely if the community organization serves a large metropolitan area or contiguous communities—then some resources should be allocated to dissemination of training and materials. Cost-effective means are the use of a Trainer of Trainer (TOT) model, by which previously trained program implementors train implementors outside of the community; and the development of a materials clearinghouse, by which one or more committees of the community organization periodically collect, review, and recommend prevention program materials to other communities. Both of these methods are used in the Midwestern Prevention Project to disseminate drug prevention program components throughout several states (Pentz and Valente, 1993).

Outcome

A detailed discussion of prevention research methods that are appropriate to the study of community organization is beyond the scope of this paper. However, several previous studies of community action and community and school prevention programs have yielded recommendations for measurement of com-

community organization outcomes. Measurable outcomes of community organization include changes in prevalence rates of the target health behavior; generalization of organizational and prevention program effects to other related health behaviors; changes in community acceptance of the initial problem and social norms for the target health behavior; increased centrality of community leader and interagency communications and cooperation; increased community leader and resident perceptions of empowerment *and* capacity to empower other leaders and agencies for long-term health initiatives through policy change; and institutionalization of prevention programs in the community.

Experimental studies of community organization, with community as the unit for randomization, are rare and may be prohibitively expensive. Quasi-experimental studies using communities that are demographically matched, convenient, and ready for intervention must attempt to control for secular trends and expected confounds that derive from initial differences and changes in the physical, social, and psychological characteristics of communities (Cook and Campbell, 1979; Van de Ven and Ferry, 1980; Altman, 1986; Pentz, et al., 1986; Boruch and Shadish, 1993). Units of analysis within communities may differ according to the target of community organization tasks (Stevenson, et al., 1992). Changes in community organization networking may best be measured and analyzed by block-modeling procedures, network analyses, and evaluation of mean changes on scales of interorganizational relationships (Rogers, 1974; Freeman, 1978; Valente and Pentz, 1990). Changes in other variables may be assessed with self-report, other-report, and archival measures, and analyzed with regression or time-series analyses that model or adjust for secular trends.

Ethnic/Racial Community Considerations

The proposed model for community organization and community prevention research is intended to apply to all communities, with individual differences determined by the presence or

absence or levels of specific variables representing each construct in figure 1. However, communities that are populated by one dominant ethnic/racial group or mixed ethnic/racial groups, or are experiencing a rapid in-migration of one or more ethnic/racial groups, may be subject to several variables that serve as "stressors" on the community's capacity to organize effectively for prevention compared to other communities. These stressors include but are not limited to the following. An Anglo-Saxon dominated government and culture in the United States tends to attribute ethnic/racial community problems to inferiority, genetics, or a failure to socialize; these attributions tend to depress community resident feelings of empowerment and categorize community leaders and agencies as passive recipients of government and social services (Tuchfield and Marcus, 1984). The pervasive myth that ethnic/racial communities and populations are automatically at high risk for health problems, drug abuse, and criminal behaviors has a self-fulfilling prophecy effect as well as decreasing perceptions of empowerment (Legge and Sherlock, 1990-91). Difficulty of acculturation to a majority—usually White—social norm for behavior, and secondary problems in acculturation conflict between adults who may prefer retention of another culture and youth who prefer rapid acculturation to majority norms, weaken the capacity of a community and its residents to cope with other, daily stressors, such as job and school (Caetano and Medina-Mora, 1988).

Attempting to accommodate to majority norms, ethnic/racial communities may show an unusually high tolerance for conditions that would be considered unacceptable to other communities. Thus, by the time a critical incident or initiating event to community organization does occur, it may serve as a flash point for aggressive or destructive behavior before positive organization can be realized (Oetting and Beauvais, 1991). Finally, access to professionals and resources, formalized organizational structure, and subsequent longevity of community organizations shown in community heart studies and the MPP may be unrealistic for most ethnic/racial communities, which are isolated from these resources. The net result in these communities may be a slower, less visible, less powerful community organizational

process compared to other communities, with a distrust of majority-dominated government and social services that renders achievement of policy change and dissemination outcomes difficult.

Table 5-1 shows four case examples of communities that vary in their ethnic/racial makeup, with realistic goals and directions for community organization and research. Although the community organizational strategies for each are hypothetical, the communities themselves are based on real examples encountered in prevention studies. The rural, Native American community is based on communities participating in the Tri-Ethnic Center at Colorado State University (Altman, 1986). The rapid in-migration of Vietnamese and other Asian groups along a major interstate that crosses a White community is based on a pilot prevention project in Tustin, California (Pentz, et al., 1986). The primarily Hispanic community within a larger mixed ethnic/racial metropolitan area is based on a proposed cervical cancer prevention study in East Los Angeles (Pentz et al., in preparation). The primarily Black city with community units organized as blocks is based on initial efforts by Corporations Against Drug Abuse (CADA) to disseminate portions of the Midwestern Prevention Project programs in wards of Washington, D.C. (CADA, in progress). Note that law enforcement cooperation, grassroots organization, volunteer resources, minimal demands for professional training, and late-stage involvement of researchers predominate in these community examples to match organizational strategies to existing resources and minimize further stress on day-to-day community functioning.

The Midwestern Prevention Project

The Midwestern Prevention Project (MPP) is an example of a research-based community organization in a large metropolitan area. Details of MPP organization are provided elsewhere (Pentz, et al., 1986; Alexander, et al., 1988; Pentz, et al., 1990; Pentz and Valente, 1993; Pentz, in press; Pentz and Montgomery, under review). Briefly, the MPP is a multi-community, multi-component drug abuse prevention program for adolescents being con-

Table 5-1. The General Model Applied to Hypothetical Case Examples of Minority Communities: Organizational and Research Directionst

COMMUNITY				
Phase of Community Organization	County, Rural Native American	Small City, White w/ Vietnamese Corridor	Hispanic Community within Metropolitan Area	Primarily Black City
Baseline Community Characteristics	<ul style="list-style-type: none"> • Low mobility • Low SES* • No business - N • Low density reservation clusters • Community unit = tribe • Adult/youth acculturation conflict - Y • Sense as victim - Y* • Isolated - Y • Empowerment - N* • Affiliation - N 	<ul style="list-style-type: none"> • High mobility • Mixed SES • Small business - Y • Mixed density • Small neighborhoods • Community unit = city • White equation - N • Isolated - Y • Empowerment - N • Affiliation - N 	<ul style="list-style-type: none"> • Low mobility • Low SES • Small business - Y • High density • Large neighborhood • Community unit = city section • Minority integration - N • Isolated - Y • Empowerment - N* • Minority subgroup acculturation conflict - N • Isolated - N • Empowerment - Y • Affiliation - Y 	<ul style="list-style-type: none"> • High mobility • Low SES • Own business - N • High density • Small blocs • Community unit = street block • Minority equation - N • Isolated - Y • Empowerment - N • Affiliation - N

Table 5-1. The General Model Applied to Hypothetical Case Examples of Minority Communities: Organizational and Research Directions (Continued)

COMMUNITY	Phase of Community Organization			
	County, Rural Native American	Small City, White w/ Vietnamese Corridor	Hispanic Community within Metropolitan Area	Primarily Black City
Community Organization Development	<ul style="list-style-type: none"> Community development Assess tribe/government interactions Initial focus = alcohol demand Organization = top down 	<ul style="list-style-type: none"> Community organization for alcohol/drug abuse prevention Community/school cooperation for prevention education Initial focus = community awareness of problem Develop campaign and education tasks Mass media preparation meetings Organization = bottom-up parent grassroots initiation with top-down follow-up 	<ul style="list-style-type: none"> Community organization for juvenile delinquency prevention Assess law enforcement/school cooperation Initial focus = school education Initial focus = neighborhood grass roots and top down Hispanic organizations 	<ul style="list-style-type: none"> Community development Assess volunteer efforts, law enforcement cooperation Initial focus = clean-up campaign Organization = bottom-up neighborhood/church grass roots *

Implementation	<ul style="list-style-type: none"> • Train indigenous parents/peer leaders in supportive counseling • Peer monitoring • Special events* 	<ul style="list-style-type: none"> • Plan community campaign with local media in order to commerce, minority leader representatives volunteers independent 	<ul style="list-style-type: none"> • Train teachers/peer leaders • Train parent volunteers to increase parent awareness in neighborhoods 	<ul style="list-style-type: none"> • Mobilize adult/youth volunteers*
Maintenance	<ul style="list-style-type: none"> • Research assistance for feedback • Long-term focus = development of alternative leisure activities • Acquire resources - N/A • Dissemination - N/A • Gov't involvement - Y 	<ul style="list-style-type: none"> • Research assistance for feedback and maintaining local interest • Long-term focus = regular prevention education in schools • Acquire resources from White & Vietnamese businesses & initial volunteer support • Dissemination - N/A • Gov't involvement - Y 	<ul style="list-style-type: none"> • Research assistance for feedback and maintaining local interest • Long-term focus = regular prevention education in schools/court and counseling assistance for indicted youth • Acquire local business, law enforcement, Hispanic resources • Dissemination - Y • Gov't involvement - N* • Law enforcement - Y* 	<ul style="list-style-type: none"> • Researcher assistance in evaluating effective use of social services • Long-term focus = education, leisure activities for youth • Acquire job training and job support resources* • Dissemination - N/A • Gov't involvement - N • Law enforcement - Y

Table 5-1. The General Model Applied to Hypothetical Case Examples of Minority Communities: Organizational and Research Directions† (Continued)

COMMUNITY				
Phase of Community Organization	County, Rural Native American	Small City, White w/ Vietnamese Corridor	Hispanic Community within Metropolitan Area	Primarily Black City
Outcomes	<ul style="list-style-type: none"> Youth alcohol use Acceptance of youth alcohol use Trainer empowerment 	<ul style="list-style-type: none"> Community awareness of alcohol/drug problems Community leader acceptance of minority groups Adoption of school prevention program cultural content 	<ul style="list-style-type: none"> Family responsibility for keeping neighborhoods gang free Mainstreaming of indicted youth into community service Student peer leader counseling 	<ul style="list-style-type: none"> Residential/safe zone* Protection/avoidance of gangs, crime Neighborhood* empowerment
Future Directions for Organization	<ul style="list-style-type: none"> Negotiating more control over gov't resources Lobby to remove alcohol outlets 	<ul style="list-style-type: none"> Increasing minority access to local health care and resources 	<ul style="list-style-type: none"> Integrating law enforcement officers as educators Changing school policy about drugs/ crime-free zones 	<ul style="list-style-type: none"> Acquire health care, counseling for youth Maintaining crime/ drug-free zones Developing housing construction

- Developing family/sibling alternative models for gang members resources, volunteers

Future Directions for Research	<ul style="list-style-type: none"> • Evaluate youth pressure on adults to alcohol use • Evaluate community acceptance of minority groups, empowerment of minority groups • Evaluate effectiveness of community vs. law enforcement control of gang behavior • Evaluate effects of cleanup and safe zones on residential stress, physical illness, employment
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Note. Asterisks (*) denote variables that represent common minority community issues and responses. Choice points are indicated by Y (Yes) or N (No) for each variable within each construct represented in Figure 1; variables without Y or N represent continuous variables that are not expected to moderate community organization.

ducted in the 26 communities comprising the Kansas City, Kansas, Kansas City, Missouri, and Indianapolis, Indiana metropolitan areas. The MPP is conducted as a research trial; as such, the design and implementation of all program components are based on theory and results of past prevention research. The program components are introduced sequentially into schools and communities to maintain community interest in long-term drug abuse prevention intervention. The components, in order, include: mass media programming (an average of 31 events and programs per year); a school program (11–13 sessions in grade 6 or 7, followed by a 5-session booster in grade 7 or 8; and a multi-component high school environmental change program that is currently under development); a parent program that includes parent education and organization throughout middle school; community organization that includes initial and continuing training of community leaders in drug abuse etiology, epidemiology, and prevention; a series of short- and long-term programs, campaigns, and policy change initiatives that complement other program components; and local health policy change at the town and city levels, including the promotion of beer taxes and smoking ordinances.

Unlike the community heart studies, community organization in the MPP was delayed until the effects of other program components could be fed back to the community as a “success” to motivate long-term commitment to organization. The community organization in each site is a formal organization for drug abuse prevention that is organized at the city level, with formal and informal leaders who represent the interests of each community within the metropolitan area. Eleven committees serve as substructures within each organization to implement prevention programs, campaigns, and events. The committees are organized according to research and community service function—for example, research, medical, and recreational youth committees.

The predominant ethnic/racial group in both cities is Black (approximately 19%), although Hispanic representation has grown to over 5% between the 1980 and 1990 U.S. Census. Ethnic/racial interests are given special attention in each community organization via a separate committee, the Ethnic/Racial Issues

Committee, that is structured to conduct additional needs/resources assessments for ethnic/racial groups, adapt program content and campaigns to special cultural needs (for example, reinterpreting reinforcement of implementors and participants in the form of a youth rap contest), and plan effective strategies to maximize participation of ethnic/racial groups in programs (for example, relocating parent group meetings to churches rather than schools). The community organization in Kansas City, the Kansas City Drug Abuse Task Force, has been in operation since 1987; the organization in Indianapolis, the I-STAR Community Council, has been in operation since late 1988. Both community organizations have reported positive outcomes in adolescent drug use behavior, changes in community social norms for drug use, increased inter-leader and interagency communications and cooperation regarding delivery of drug abuse prevention and treatment services, dissemination of the school program component throughout their respective states, and initiatives that are expected to result in prevention policy changes at the school district and city levels.

Gaps in Community Prevention Research: Future Directions

A recent Office of Technology Assessment (OTA) report (United States Congress) and a book published by the Carnegie Corporation, "Fateful Choices," (Hechinger, 1992) concluded that adolescent health is worsening in the United States for the first time. The reports represent a call to Congress, State governments, and communities to organize for comprehensive health promotion at the community level. Community organization would aim jointly at community development to get at the root stressors that contribute to disease risk, specific community organization to prevent disease risk behaviors that are co-morbid for several health and social problems, and promotion of healthy alternative activities in communities.

If Congress follows through with these recommendations, more research will be needed in multi-focused community organization and community organization for health vs. disease pre-

vention, and community development for primary prevention of poverty. Other, more specific directions for research include evaluation of how and under what conditions community organization at relatively small levels, e.g., street block, can be expected to diffuse to much larger levels, e.g., an entire metropolitan area; and the conditions under which a top-down, bottom-up, or combined model of community organization may be indicated in ethnic/racial communities. In addition, before communities take on more complex organizational tasks for health, systematic evaluation should be conducted on how and how effectively communities are using current funds from the Center for Substance Abuse Prevention Community Partnership grants and other Drug Free Schools and Communities monies.

Final Caveats: Contraindications to a General Model

This paper focuses on *adaptations* of a general model of community prevention research to ethnically and culturally diverse communities, based on theory and previous research findings. However, reflecting the predilections of researchers and academicians who developed these theories and research findings, it could be argued that the general model described here is a rational decision-making model built on Western (primarily Anglo-Saxon) principles of leadership and community organization; culture-free concepts of behavior change, most notably, behavior modification concepts from social learning theory; and initial prevention education strategies that rely on person-level predictors of and solutions to drug abuse. Evidence is growing to support adaptations of this type of general model to diverse populations. The most recent example may be the current organizational efforts of communities participating in Robert Wood Johnson's Fighting Back program. Two years after planning community wide drug abuse prevention, culturally and ethnically diverse communities that initially attempted to organize from the perspective of community vs. expert-driven initiatives have evolved through organizational, process, and structural models very similar to those presented here (Pentz, 1993). Nevertheless, at least

three exceptions should be noted for which any adaptation of a general model may be contraindicated. Since none of these exceptions have been thus far evaluated or validated as contraindications, they are presented as hypothetical constraints to adapting the type of general community model of prevention research described in this paper.

The first contraindication is a community with a negative history, if not outright failure, of previous researcher involvement in community organization for prevention. This contraindication pertains to any community, regardless of ethnic/cultural representation. The negative history would go far beyond simple distrust of government services or professional involvement as discussed earlier, to outright refusal of the community to adopt or follow any protocol that is specified *a priori*. In this case, the community should anticipate a development period that is characterized by multiple regular challenges from competing interest groups as they vie for attention and support. Formalized data collection may be antithetical to the interests of all groups. However, informal accounts of community process can be collected to document the community's "story" for future self-accountability and for re-creations of the story in other communities interested in replicating the process.

The second contraindication is a community with such diverse interest groups that consensual, organized leadership for prevention is not possible. Like the previous example, this contraindication pertains to any community, regardless of ethnic/cultural representation. In this case, it is conceivable that diverse groups develop their own separate agendas for prevention within the community, and meet only temporarily for agreeing to principles of least harm or infringement to each other and to the community. For example, after the civil unrest in Los Angeles riots, gang leaders met and formed a temporary truce for peace, without relinquishing their own operations or developing concrete plans to positively restructure their communities. Faced with this type of contraindication to a general model, a community may be expected to progress through several slow stages before organization for prevention can be attempted, from a temporary alliance for least harm, to some community healing

after harm has been reduced, to tentative consideration of proposals that promote growth of separate interest groups while maintaining least harm to others.

The third contraindication is a community with perceptions about drug abuse, prevention, and treatment that are radically different from rational, intrapersonal, time-limited, and expert-dependent theories and research of Western, White culture. This contraindication is specific to communities that are predominantly ethnic/racial, either in terms of representation by a single ethnic or cultural group or by diverse groups. For example, a recent review of anthropological, sociological, and psychological research on health attributions indicated that ethnic/cultural minorities construe illnesses such as drug abuse as a long-term process caused by natural, interpersonal and environmental, and supernatural (including mystical retribution, hot-cold attributions, and bad blood) factors (Landrine and Klonoff, 1992). Furthermore, prevention and treatment are perceived as an ongoing, evolutionary community and family healing process rather than as a time-limited strategy developed by health experts. Researchers attempting to work in such communities are advised to conduct a thorough formative evaluation before determining whether any rational, deterministic model can be applied to prevention. Rather than a prevention needs and resources' assessment based on available services, a formative evaluation would first consist of evaluating how the population identifies or labels drug abuse and its symptoms, attributes causality, anticipates consequences, and expects a course and duration of "cure." If the formative evaluation yields findings that do not fit current theoretical and research schemas of drug abuse prevention, the researcher's subsequent role may be observer and documenter of a community process that may or may not develop into an organizational model, and may or may not be generalizable to other ethnic/racial communities.

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6

Ethnic Communities and Research: Building a New Alliance

Fred Beauvais

Introduction

The original version of this article was much different from what follows. During the first writing I had in mind the notion that those who did social research were somehow inherently at odds with those who were the subject of their inquiry. I was following the supposition that researchers had a world view that differed significantly from non-researchers, and in particular differed from ethnic minorities, and that these differences set the stage for a series of conflicts that had to be overcome if social research was to achieve its goals. This belief in opposition, conflict resolution and compromise is rooted in the theories that commonly drive cross-cultural research. Cultures, including research as a culture, have been viewed as competitive; and, to achieve accommodation, one side or the other must give ground. I pursued

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this line of thinking in the original writing; but, I was disturbed by the feeling that something did not ring true.

When I was doing the final revisions of this paper it occurred to me that what I was writing was not congruent with the most recent research of our laboratory, and that realization accounted for my unease. We have recently theorized, and have partially substantiated, that the coming together of two cultures need not be marked by conflict and that cross-cultural encounters can be mutually enriching with no necessary loss to either culture (Oetting and Beauvais, 1990). Is it not possible to see the coming together of scientific and ethnic communities in the same non-competitive light? Armed with this insight, I went on to revise the paper and with much less anxiety. This change in focus is reflected in the change in titles: the original article was titled "Reconciling the Requirements of Science and Community in Cross-Cultural Research," which clearly connotes a different view from "Building a New Alliance."

The Culture of Science

Using the term culture in its broadest sense, scientific research forms a culture by itself. There are specific beliefs, values, and behaviors that accompany the scientific quest for knowledge. The presence of rituals is even an essential element of science, as evidenced by dissertation defenses, group behavior at conferences, study sections, the requirements of professional publication and the like. In the course of its business, the culture of science routinely comes into contact with other cultural groups, often resulting in awkwardness, if not outright discord. The most common encounters are with non-scientists, and, while these are often marked by some uneasiness, there is often a larger, shared cultural background that allows for a modicum of communication and understanding. Physicians, for instance, are usually able to call upon shared language and metaphors to help their patients understand their illnesses and treatment.

When science has to transcend not only its unique culture but also to cross boundaries presented by ethnic and nationality differences, the potential for tension increases. This is a common

circumstance when social scientists are involved in the investigation of problems in a culture other than their own. In these instances there are layers of differing expectations, world views, and perhaps language that must be adapted to if the work of science is to be successfully completed. It is too often the case that the scientist and the community are operating in different spheres and toward different ends. The net result is mutual disappointment with the research process and perhaps even lingering distrust.

The origin of much of the tension that occurs when different cultures come in contact is the belief that the cultures are in competition and that if the values of one culture are embraced, then the other culture is diminished. The bulk of the literature on acculturation is based on this premise whereby cultures are placed at polar opposites on a single, linear dimension (Oetting and Beauvais, 1990). Movement along this dimension in a particular direction implies that if a person is gaining identification in one culture, that person is losing in the other. These linear models assume, for example, that if someone from Puerto Rico wants to become a successful college professor in Seattle, he must leave behind many rich cultural elements he has been imbued with in his native upbringing. Another tenet frequently encountered in these models is that if a person takes on identification with another culture there is an inherent transition period that is marked by stress and conflict. This is only resolved when identification is achieved with the new culture and the old values, behaviors, and customs are left behind.

The linear model of acculturation, emphasizing cultural conflict, has not been particularly helpful in explaining the process of changing cultural identification. An alternative model has been proposed that does not involve the notion of inherent conflict when cultures come in contact (Oetting and Beauvais, 1990). Applying this model to the encounters between scientists and non-scientists, particularly in cross-cultural settings, reduces the focus on conflict between cultures and enhances the possibility that a more effective, workable alliance can be built.

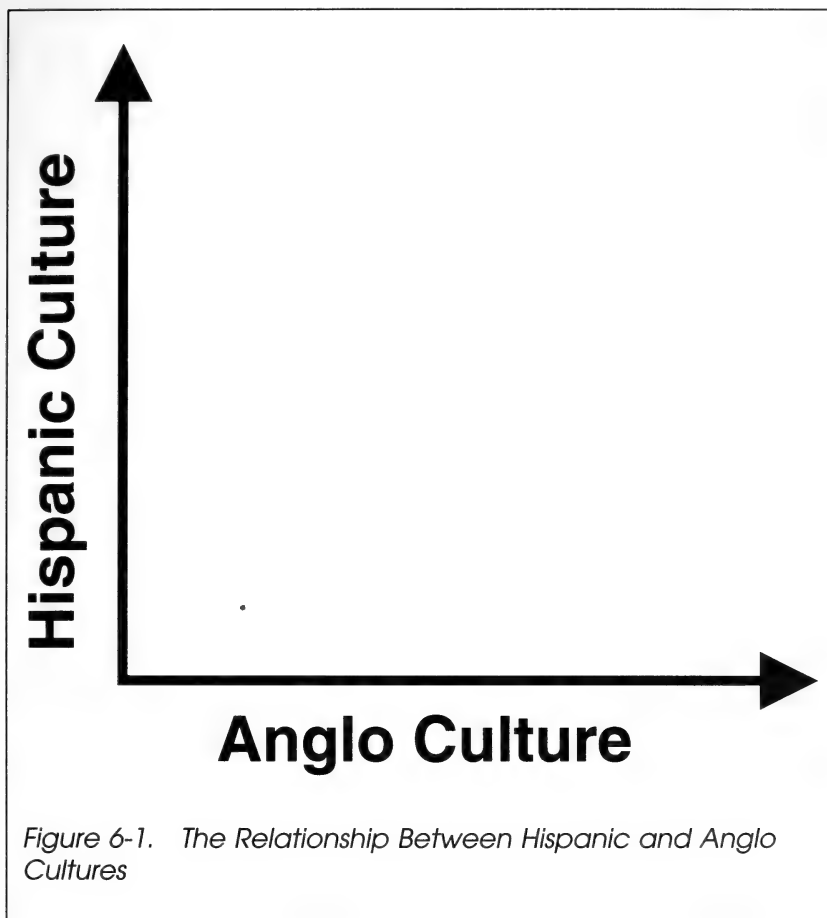
This alternative model of cultural identification is presented in figure 6-1. Each line represents a different culture: one repre-

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sents Hispanic culture, for instance, and the other Anglo, or White American, culture. The base point, or origin where the lines meet, marks no identification with either culture. A person who is highly identified with Hispanic culture could be said to exist at some distance from the base point (the farther along on the line, the greater the strength of identification with Hispanic culture). At some point, however, the Hispanic person, by choice or circumstance, may meet Anglo culture and begin to assimilate some characteristics of that culture. This person's identification can now be visualized as moving out at right angles to the Hispanic dimension in the direction of Anglo identification. The important point is that by moving in the direction of increasing Anglo identification, it is not essential to lose one's "Hispanicness"; that is, there is no necessary movement toward the base point. The person can retain as much of the original heritage as desired, while adopting any level of identification with another. The culmination of this process might involve complete identification with both cultures (in other terminology, "biculturalism"); when this occurs the person can be visualized as being in the upper righthand corner of the space defined by the two axes.

If, in the model, we replace one culture with "science" and the other with an ethnic culture, we have a model with strong implications for cross-cultural research. In the present paper, those from an ethnic culture can become conversant with the goings-on of science and the culture in which it exists without necessarily detracting from their native cultural beliefs, values, and behaviors (See figure 6-2). In the same manner, members of the culture of scientific research can come to understand and appreciate the values, beliefs, and traditions of ethnic groups with whom they may be working, and in doing so they do not have to "compromise" or leave behind their scientific values.

It is important to note that there are varying levels at which identification with another culture can take place. The researcher may never become completely identified with another culture, but there must be substantial movement in that direction if there is to be a productive alliance. A researcher, for instance, can gain knowledge about the traditions of an ethnic culture but not consider these traditions to have any legitimate value in the



study of social problems. For instance, a particular tribal group may follow certain behaviors surrounding taboo topics or events; and, while the researcher probably could describe these behaviors, little or no identification is achieved and the researcher may dismiss these behaviors as "superstitions" that have no place in "correct behavior." This scientist is not moving out into the bicultural space and is sticking to the "scientific" culture and only observing at a distance. Science and the native culture at that point may be in conflict. When the scientist later describes the behaviors in unsympathetic terms, the native people may resist further involvement with the scientific process. While it

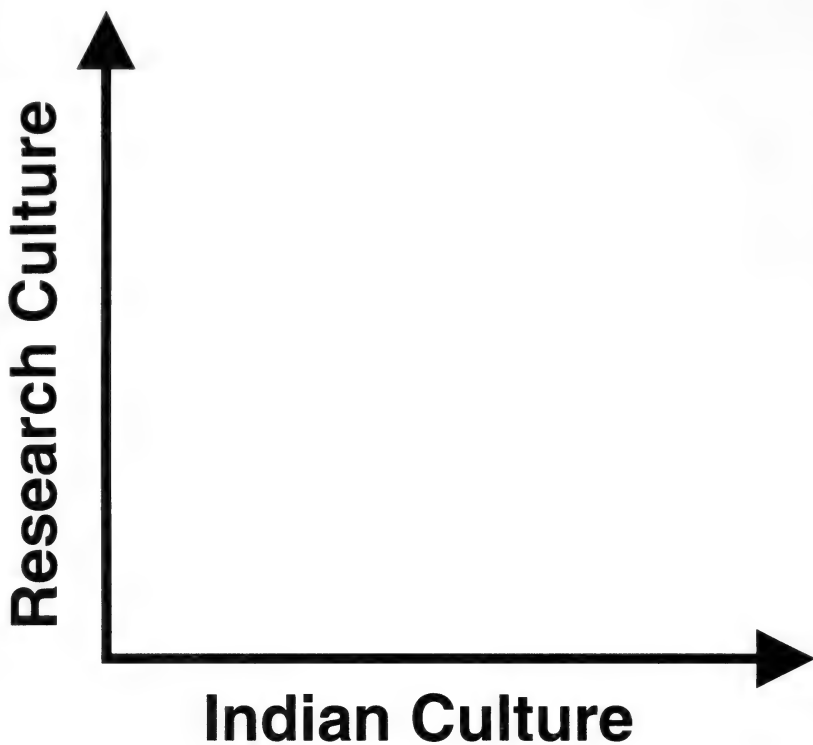


Figure 6-2. The Relationship Between the Research Culture and Indian Culture

may not be necessary for researchers to incorporate those taboos into their own value system, they must at least “suspend disbelief” and acknowledge that taboo behavior is a valid part of the tribal world view and something to be seriously reckoned with in conducting research. In essence, the researcher need not become totally accepting of the world view of another culture to guide his or her own behavior. However, there is a need to become identified with that culture to the extent that its world view is seen as valid and to expand research strategies to accommodate the assumptions of that world view. More will be said on this point later.

Conflict can arise, and it does so primarily because of the failure to appreciate and to identify, with the needs that are inherent in the culture of another, thus not taking these needs into account when trying to negotiate a cross-cultural interchange. The theme of this paper, then, is to identify the possible needs of the culture of science and the cultural needs of ethnic communities, to show how increasing identification with both cultures can reduce conflict and help build working alliances.

Community Needs and the Purpose of Scientific Research

In its purest form, the intent of science is to accumulate knowledge and understanding of natural phenomena with no particular requirement that the findings will be useful in the sense of creating change in the world. This is in sharp contrast to the needs of the community that may be experiencing social problems, in ethnic communities all too often accompanied by high levels of human misery. Unfortunately, and for a host of historical reasons, ethnic communities are often in the greatest need of immediate action to remedy social problems. When these communities are approached by the scientist interested in study of problems, there can clearly be a mismatch in expectations: the scientist is looking to further knowledge while the community needs a resolution to a problem. The mismatch, however, need not be overdrawn, since there does not have to be anything contradictory between rigorous science and social action; the resolution lies in the need for the researcher to understand the need for action and to design research that addresses problems in a way that leads to short-term solutions, while adding to basic knowledge in a scientific field. An example may be useful.

A social scientist may have an interest in the social and psychological conditions leading to patterns of suicide among adolescents and may want to test out some cross-cultural hypotheses by doing research in ethnic communities. Pursuing this interest would require a great deal of data collection, statistical comparison, perhaps some complex model building, and ultimately the publication of research results. To this point the

requirements of science are met, but it is entirely possible that these results may have little practical application in the community. It is quite often the case that this type of research is conducted in communities where the problem is particularly severe and thus the need for solutions is urgent. When the scientist gains prestige and publication and the community gains nothing, it can be viewed as exploitation. With forethought and planning, however, it is possible to attend to both the research goals and the needs of the community.

The key to meeting both sets of goals is collaboration in setting the research agenda. Community people need to be involved so that they can state their needs in terms of the types of answers that would help them address the problem. This process need not be disruptive to the scientific process but can be seen as an extension of that work to the practical level. Early dialogue has the advantage of aiding the research effort by making certain that the issues addressed are framed accurately, thus leading to more accurate research outcomes. Knowledge of the local context may modify the research questions and ensure that the right questions, and thus the most useful answers, are ultimately arrived at.

It must be recognized that sometimes science can have abstract goals that do not easily lend themselves to practical application. In these instances it is appropriate to develop an additional set of research goals that address the immediate needs of the community but are still congruent with the thrust of the research efforts. For example, a research project may be addressing the theoretical links between psychosocial factors and substance abuse among adolescents, but at the same time efforts could be designed to incorporate these findings into a drug prevention curriculum for use in community schools.

For its part, the community must develop an appreciation for the time demands of research and understand that immediate recommendations for problem resolution are not always possible. One common type of cross-cultural research, for instance, is the replication of findings from the majority population to an ethnic group. For example, suppose it has been found that a particular intervention has been shown in the general population

to be effective in reducing drinking among pregnant women and thus a reduction in the rates of fetal alcohol syndrome. In an ethnic community experiencing high levels of fetal alcohol syndrome, there may be a serious and immediate need to adopt this type of program. The researcher, however, may see a need to test the efficacy of the intervention within the ethnic population. It is possible that within a different cultural context the program that proved effective elsewhere may not work, or may potentially have a harmful effect. Through collaboration with the researcher, community people can come to realize that this cross-validation effort is often necessary (i.e., a requirement of the culture of science) to see if the original results generalize to their community.

Evaluative research is another area where the lack of a bicultural orientation can create a mismatch of expectations. Programs to address social problems are usually implemented because there is a serious and immediate problem that needs to be addressed. The researcher's interest is in questions regarding the efficacy of the program in meeting predetermined goals. Routinely, these goals are specified and measurements are used to assess their attainment and to determine which aspects of the program are effective and, if possible, why. The ultimate objective of this type of inquiry, from a scientific perspective, is to see if the program has a coherent enough theoretical base to be transportable to other contexts.

In some ethnic communities, however, the objective may be much more pragmatic and may involve many questions that cannot be answered through the usual empirical approaches. Quite often these questions are rooted in social and cultural issues and may include: Is this program congruent with our cultural values and traditions? Do the community elders value this program? How does this program fit in with already existing human service programs? Is the program displacing existing programs? Will the program add new employment to the community? Once again, it is not necessary to see the goals expressed by the researcher and those of the community as being in opposition to one another. The researcher needs to be aware of these other domains of inquiry and make certain that the evaluation

plan incorporates answers to the questions that are deemed important by the community. The reasons for this are both ethical and pragmatic. The researcher cannot assume that his or her way of framing research questions is the only valid one; to do so perpetuates the same colonial attitudes that have plagued the relationship between research and ethnic communities in the past. Pragmatically, if the community does not receive the answers it deems necessary from a piece of research, the opportunities for future collaboration will be greatly diminished through restriction of research by ethnic communities.

Ways of Knowing

The problem of misunderstanding between researchers and ethnic community people may go even deeper than differences in expectations regarding the purpose of research. There may be fundamental differences in world view and ways of structuring knowledge that must be considered.

Western scientific thinking follows a fairly consistent and accepted (at least by researchers within that specific culture) set of rules for the accumulation of knowledge. These rules are largely quantitative and rely heavily on statistical inference. The success of science in solving certain problems has led many researchers to become culture bound and to lose sight of the fact that knowledge can be accumulated in a number of alternative ways (See Berry, 1980, and Goodenough, 1990, for an extended discussion). Many cultures, for instance, often rely on more qualitative processes to derive meaning from their observations and to transmit this meaning to others. In some cultures there are strong oral traditions where information is conveyed through stories or legends passed to younger generations by elders. Furthermore, truth or knowledge rarely hinges on linear logic with successively linked pieces of evidence leading to a conclusion. Rather, for some cultures, knowledge comes from an accumulation of information and sometimes from seemingly disparate sources. Pieces of knowledge are woven together, often in allegorical fashion, and conclusions may not be evident to someone not familiar with the cultural themes. The point is that the usual

quantitative research strategies may lack face validity in many ethnic communities. The collection of numerical data does not appear relevant, and there may be resistance to data collection.

This seeming disparity between cognitive approaches need not become a barrier, however, since multiple methods of research can be used, with each source of information enriching the other. Fortunately, there is an increasing appreciation within the research community for ethnographic approaches that can be used to capture meaning within cultures with strong oral traditions or more metaphorical cognitive styles (Gilbert, 1990; Goodenough, 1990; Ramirez, 1983). These approaches are more likely to be accepted within ethnic communities and can be used with the quantitative methods usually associated with Western science. Again we have the opportunity for different cultural traditions to be blended and used simultaneously, rather than to be seen as in opposition.

Access

Research has developed a checkered reputation in ethnic communities over the past few years (see, for example, Manson, 1989). The reasons for this are varied but typically are due to the oft-repeated failure to perceive the multiple cultural needs of both the researcher and the community. Regardless of the origins of the adversarial stance often found between ethnic communities and researchers, the researcher must be aware of these feelings before a community is approached and must recognize their legitimacy. Without this sensitivity to history, the researcher will likely misread the mood of the community and encounter roadblocks in gaining access.

Access to a research population is contingent on both the needs of the researcher and the needs of the community. Ideally, the balance of needs is equal, but it has quite often been the case that ethnic communities have been perceived as field laboratories to be used for the convenience of the researcher. This can lead to a sense of exploitation within the community and an unwillingness to participate in future research efforts. It is unfortunate that many communities feel that they have been sufficiently

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"burned" in the past that they have put stringent regulations on further research. Sometimes the problem has become severe enough that the community has imposed a total ban on research (Trimble, 1977; 1988). While there may be legitimacy to this type of feeling, the community must also realize that research can, under the right conditions, lead to problem resolution and that banning of research can be self-defeating. There are many antidotes to this type of community resistance, most of which stem from an attitude of persistence and respect and a willingness to learn on the part of the researcher.

A major error in many failed research projects is the lack of sufficient lead time in which the groundwork for the project can be established. Sufficient time must be allotted in which researchers can meet with community people to discuss the planned research and to give the community an opportunity to help shape not only the goals of the research but also the procedures that will be used. The importance of this planning stage cannot be overstressed, and it is important to allow enough time for this process to take place. This is the time in which differences in world view often emerge and the process of cross-identification between cultures starts to take place; community people can be educated regarding the needs of research and researchers can gain deeper insights into the cultural milieu in which they will be working.

A major issue to be addressed early in the research process, and indeed one that needs to be revisited throughout, is who is responsible for change that might result from the findings of the research; this is important when the issues under study are of a social nature. The history of ethnic group social change in the United States is one where outside groups have attempted to impose solutions to social problems; for the most part this has not been successful. For instance, for over 200 years federal government policy held that American Indian communities would be better off if their children were educated in boarding schools run and staffed by non-Indian teachers. This has led to poor educational achievement for many Indian youth and further has disrupted family functioning, since children were essentially raised in a non-family environment. Today there is a strong trend

toward educating Indian youth in their home communities and to a growing extent by members of their own tribe.

It is well accepted in the field of community development that the deepest and most lasting changes in community life are generated from within the community and not by outsiders who have no lasting investment in the welfare of the community. It is reasonable, therefore, that the impetus for change come from community members themselves. Research results can be useful by providing data regarding the need for change, the direction of change, and the extent of change, but the researcher is not the best change agent. As indicated, these expectations must be made clear from the beginning. Because it has happened so often in their history, it is not unusual for an ethnic community to assume that the outside research team will take the lead in implementing change once research results are available. If the researcher is not expecting to take on this role, and the community is expecting it, there will be a sense that an implied contract has not been fulfilled and resentment may follow.

While the above cautions are especially pertinent in research projects involved with social research, they are also relevant to all types of investigations, including medical research. A physician may, for instance, be able to pinpoint the underlying causes of an outbreak of infectious disease in a community and devise a plan for its treatment. Although this may involve straightforward medical and public health procedures, compliance with those procedures may well be contingent on local social and cultural factors. The people in the community must be educated as to the necessity for compliance, cultural barriers to the treatment must be addressed, and the indigenous health care workers must be enlisted in the effort. Lack of attention to any of these links to compliance could well lead to poor adherence to the treatment regimen.

Apart from recognizing and acknowledging whatever feelings there are in a community about research, access for the researcher is also contingent upon knowing and using the proper channels for approval. Ethnic communities, trying to retain a sense of ethnic identity, have often developed a certain level of autonomy that is maintained by both formal and informal

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regulatory structures not found in mainstream communities. American Indian communities present the clearest example, since they see themselves as independent nations with a direct formal relationship with the United States government. The fact that a research project may be federally funded, however, does not automatically imply access to Indian communities. There are many local government structures that must be consulted and that must provide approval before research can be sanctioned.

In other ethnic communities the controls are less formal, yet there may be important gatekeepers who must be apprised of proposed research and must give approval. Besides approval by gatekeepers, researchers must be sensitive to the prevailing attitudes in the community with respect to specific research content. In many Indian communities, for instance, there are topics that are either taboo or are considered inappropriate to be discussed publicly. In other communities a particular line of research may be perceived as changing the power relations in a community and thus be seen as threatening to certain factions. Proposed research that is not in tune with the local values and beliefs and political dynamics will have little chance of being approved by the community. Once again, these cautions apply to all types of research, not just that which involves social problems. Agriculture, for instance, is strongly rooted in the cultural beliefs and value systems of many ethnic communities. While it may seem reasonable to study ways of increasing crop or animal production through scientific research, such a project may not be tolerated if it is viewed as infringing upon strongly held beliefs regarding fertility and the spiritual relationships with the natural world.

On the community's part, to the extent possible, the channels of approval for a particular piece of research must be made clear to the researcher. An investigator may believe that the proper sanctions have been obtained only to find out midway through the project that there are major objections to this work by segments of the community who are in a position to block its completion. The informal nature of many control structures in ethnic communities often makes it difficult to discern where approval should be sought, and it is often necessary to rely on local collabor-

rators to obtain this information. Even when formal approval has been obtained, however, the researcher must maintain an ongoing awareness of attitudes in the community. It is a common occurrence for individual community members to voice objections to a particular piece of research and to threaten the project with termination. Without knowing the prevailing or dominant attitudes of the community, it would be easy to misread isolated complaints which might interfere with the research.

While it is important that the concerns of individual community members be heard and given a considered response, it is incumbent upon those in the community who provided the original approval to protect the integrity of the research and to make certain that vocal individuals not override what in general has been deemed valuable research.

Research Design

Whenever research is taken from the laboratory to the field, a great number of complications can arise, since rigorous designs are difficult to construct and maintain. If the proposed research is to have any value from a scientific perspective, or in terms of resolving community problems, it must be conducted as rigorously as possible. It is occasionally possible to set up a true experimental design in the field, but the complexities of the real world most often dictate that quasi-experimental designs are the most feasible. Even these designs, however, carry with them the need to structure the research in systematic ways that often conflict with the needs and capabilities of the community, or that are misunderstood by the community. Random selection of research participants and the need for control groups are two of the most common issues that create problems for field research. The scientist needs to be certain of the validity of any piece of research, but the community may see these as unnecessary trappings that only delay the implementation of sorely needed interventions. A community that is facing a rapid increase in cases of HIV infection, for instance, will understandably be impatient with the need for scientific rigor. It must be recognized that local service providers are often subjected to strong expectations

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from the community to provide the best service to the most people. Parents, for example, may express dismay that their children are not receiving the benefits of an experimental AIDS prevention program because they are in a control group.

Compromises are certainly possible when research designs are developed, but the community must be aware that there is a level of compromise that will destroy the quality of the research. When this happens, the value of an experimental intervention may be unknown. The study will not provide knowledge that is credible or that can be generalized to other communities. For example, to obtain the maximum amount of scientific rigor, a no-treatment control group may be incorporated as part of the design. However, it might be appropriate to guarantee that those in the control group will receive treatment in later stages of the project. From a scientific viewpoint this may not be necessary, and may greatly increase the cost of the project, but from an ethical and collaborative point of view it may be essential.

Not only must the needs of good science be protected, but also there is the need for researchers to be responsive to funding agencies and their peer review committees. Research funds are limited, and any community-based project must compete with other projects, many of which can incorporate very sophisticated designs. Research designs that are seriously weakened by pragmatic needs of the community will not be funded. The community needs to increase its sophistication about the scientific culture to improve chances that it will be involved—that at least some of its members may receive treatment or that lessons will be learned that will eventually improve the well-being of its members.

One of the most straightforward, but often overlooked, remedies to this situation is the sharing of information with community members about the needs of good science—that is, striving for an increase in community identification with the culture of science. Researchers often assume that ethnic community members cannot understand the work of science and thus pass up a good opportunity for education and acculturation to the ways of science. Much of this can be accomplished through the use of local people who can “translate” the scientific concepts into

that are central to the important research hypotheses, thus reducing both stress and resistance among community members.

Publication of Research Results and Community Reputation

Publication of research findings for scrutiny by peers is a hallmark of science. This self-correcting process assures the accuracy of research findings and places them in a forum where knowledge can accumulate within a discipline. Researchers addressing social problems, however, often face a dilemma when it comes to publication. By their very nature, social problems entail sensitive information that may reflect negatively on the communities and the people with whom the research is conducted. A community that is beset by numerous problems may be reluctant to have yet one more piece of information appear publicly that would cast them in a negative light.

Although publication is a necessary part of research, a great deal of sensitivity needs to be used in the way reports are written. It should be obvious that individual anonymity be protected; however, there have been instances where individuals or families were identified in research publications or their identities were so thinly veiled that identification was possible by other people in the community.

Usually it is not necessary to use specific location names in reporting research results. This is especially important with smaller communities where there may be a tendency to attribute identified problems to all of the individuals who live there.

One procedure that has proven helpful in avoiding problems with publication is to have people from the community review articles before they are published. There should be agreement that this review is for protecting the reputation of the community and not to change any of the data or to alter conclusions that have been drawn from the data. The scientific integrity of publications needs to be protected as well as the privacy of the community. This type of review has the added advantage in that local people can often provide cultural insight that helps expand and enrich the interpretation of the research findings.

An often overlooked aspect of the dissemination of research information is the community's need for feedback and understanding of the research results. One reason for participation may be that they have seen the possibility of resolving a particular problem, and they have the right to information in a form that is clear and understandable. Special reports of the research findings and open community meetings are common avenues for this type of communication. In many ethnic communities it is often appropriate for someone from the community to become conversant with the research findings so that he can convey the information in a way that is understandable and is culturally appropriate.

Research Consistency and Community Dynamics

Typically it is difficult to change a research design once it has been established. The integrity of the outcomes can be jeopardized if the control conditions are altered, if the data collection procedures are changed, or if access to participants is halted. Periodic changes in the community structure or political reality, however, may seriously interact with the conduct of an ongoing research project. This is more often a problem in highly polarized communities where factions may have taken a position with regard to the value of the research.

The researcher must take an extremely cautious position when there are strong divisions in a community and when the research project has become a point of contention. It is often necessary to alter the goals of the research and work toward compromises that do not interfere with the dynamics of the community. Despite a strong desire to maintain the integrity of the research project, it is usually counterproductive, if not presumptuous, for the researcher to attempt to alter the political conditions in a community. If the work of the research project could benefit from some type of community intervention, this should be done by a community member who is familiar with the research and has legitimate influence in the community. Such liaisons should be built in from the beginning of a project, and

those local community members should take the lead in preserving the conditions necessary for completion of the project.

Collaboration

The working out of an approach involving increased identification of both scientists and community members with the culture of the other group can best be accomplished through a truly collaborative relationship between researchers and community members (Trimble, 1977; Fawcett, 1991). A great deal of prior research in ethnic communities has been almost exclusively directed by researchers, with community members expected to play a passive, or at most supportive, role. A major difficulty with this approach is that problems are often poorly defined, since they do not consider the real conditions of the community and thus are consequently of little help to the community. Furthermore, unless the community context, including especially the cultural context, is understood, research is likely to arrive at incomplete, if not erroneous, conclusions. For example, the study of health care utilization patterns in a certain community can only be understood in light of traditional beliefs about health and illness.

Collaboration with community members, then, must begin early in the research process and include problem definition to ensure that the research is relevant to the community and well conceived scientifically. Methodological issues must also be addressed collaboratively to ensure that local values and customs are followed. A study that includes household interviews, for instance, would not be well received in a community where it is considered impolite for a stranger to approach one's house. Additionally, there may be certain topics that are culturally inappropriate to ask about, and sensitive ways of collecting data must be agreed upon.

Early collaboration will usually uncover certain constraints in the community that could affect the feasibility of proposed research. In most communities there are points of resistance that need to be anticipated and worked through collectively. These could entail contacting key persons within the community who

must sanction the research, or certain structural constraints such as upcoming elections, religious holidays, and the like. Besides constraints, there may be resources in the community that can be accessed to assist in the research. In the past, many ethnic communities have been treated as if they cannot handle their own problems and that only someone from the outside is capable of doing so. If a problem exists in a community, it is quite likely that there is already someone who has at least recognized it if not made some efforts to alleviate it. Bypassing these existing efforts has often led to strong feelings of resentment by local people. In general, extensive discussions before any research is conducted in a community will have high payoff in the end. If the researcher is aware of the research history of the community, the general attitudes of community members toward research efforts, and where difficulty may be encountered, the entire process will progress more smoothly.

An additional benefit of early collaboration is the familiarization of local community members with the demands of research and providing an understanding of why certain activities and procedures are being proposed. Lacking information the community will be less likely to support the research effort. There is always the possibility that local people, once they have an understanding of the research, can suggest ways in which the research can be altered to provide an even better design or methodology.

Characteristics of the Successful Cross-Cultural Researcher

Clearly cross-cultural research places high demands on those who become involved. There are many characteristics that, while common to all research, take on added importance in the cross-cultural setting. Perhaps the most important of these is the ability to continually monitor one's own cultural boundaries and to see how these may be obscuring a full understanding of the community perspective. Related to this self-insight is the willingness to extend one's own cultural boundaries to include an in-depth understanding and appreciation of the cultural values, beliefs, and traditions of the community. It should be recognized

that the process of achieving this understanding is a lengthy one, and one that is ongoing throughout the course of the research project.

The need for collaboration between the community and the researcher has been made evident. Within this process the researcher needs to call upon skills of negotiation and compromise. There is always the tendency to push for rigorous science and to not recognize that this may not always be possible. In fact, this rigidity may prevent the seeing of alternatives embedded in the cultural milieu that eventually could produce a better understanding of the problem. Flexibility, then, is another hallmark of the successful cross-cultural researcher.

The potential for changing conditions that impact the course of research is extremely high in ethnic communities. The successful researcher, then, must be willing to constantly monitor the research project and become personally involved at the field site. It is not enough to leave the field work to others and assume that the original conditions will continue to hold. Along with the willingness to monitor, the researcher must have a great deal of endurance. Changing conditions may require modification of the research plan, a cycle that may be repeated often over the course of a project. At times it may be tempting to terminate the project due to the enormous energy required to maintain a scientifically respectable piece of work. Endurance, however, will not only see the project through but will establish trust between the researcher and community. Community people have struggled with social problems for years, if not decades or centuries, and there is an appreciation of those who are willing to persist with them and see a problem through.

Patience and a tolerance for ambiguity will also serve the researcher well. The political and decision-making processes in many ethnic communities are often complex, and their inner workings are not always apparent to someone not fully knowledgeable of the community. In some places decisions are made by consensus, a time-consuming process that requires that anyone who is interested in a problem must have the opportunity for input. This often occurs in informal settings that are not accessible to the researcher but at some future point may be

reflected in a more formal arena such as a community meeting. Deciding when all interested parties have had their say and when it is appropriate to come to a consensus agreement takes a great deal of sensitivity and insight. It is often appropriate to consult with community collaborators to determine when it is all right to proceed with certain aspects of the research.

There truly is no substitute for experience when working cross-culturally. A proven track record is vital in convincing the community that the researcher is there for the "long haul" and will be responsive to the cultural context. The researcher contemplating cross-cultural work for the first time should be willing to seek advice and validation not only from respected members of the community but also from other researchers who have had experience in the community.

Conclusion

Approaches to cross-cultural research that assume an adversarial stance between researchers and members of an ethnic community may be adding an unnecessary burden and conflict to such work. Scientists need to increase their identification with the cultures of the communities in which they work, and community members need to increase their identification with the culture of science. The needs of the culture of science and ethnic cultures can be accommodated and in fact can work synergistically in the pursuit of knowledge and problem solution. Collaborative work, although time-consuming, can add immeasurably to the work of research and will help avoid conflict that detracts from such work. Effective cross-cultural research is as much a philosophy and frame of mind as it is a series of techniques.

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Methodological Issues in Conducting Alcohol Abuse Prevention Research in Ethnic Communities

Steven P. Schinke and Kristin C. Cole

Introduction

As the science of alcohol and other drug abuse prevention has emerged and developed, investigators have devoted increasing attention to issues of cultural sensitivity (Brislin, et al., 1973; Hofstede, 1980; Marin, et al., 1992; Rogers, 1983; Teahan, 1987, 1988; Uba, 1992; Welte and Barnes, 1987). This attention is due, in part, to the realization that the frequency of alcohol and other drug abuse problems varies with their particular cultural context (Peters, Oetting, and Edwards, 1992; Schinke, et al., 1990; Schinke, Botvin, and Orlandi, 1991). That realization, in turn, follows trends in mental health research toward recognition of the role culture plays in the onset, remediation, and prevention of many mental disorders and problems (Rogler, 1989; Rogler, et al., 1987; Rogler, Malgady, and Rodriguez, 1989; Schinke, et al., 1990).

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Admittedly, cultural factors have long been addressed to some degree in alcohol and other drug abuse prevention research. As evidence accumulated showing that ethnic-racial groups differ in terms of their cultural values, norms, expectancies, and attitudes (Landrine and Klonoff, 1992), investigators began to explore targeted culture-specific interventions for alcohol abuse and other problems. But only recently have investigators begun to fully appreciate how cultural factors relate to successful treatment and prevention outcomes. That appreciation stems in part from the largely undistinguished record of past alcohol abuse prevention efforts to delay the onset of alcohol use and misuse among their target populations—particularly among members of ethnic-racial and other culturally defined groups (Moskowitz, 1989).

Among those factors responsible for undermining the effects of prevention programs in reducing the incidence of alcohol abuse is the scant attention paid to the etiology of alcohol use. The limited understanding of this etiology has complicated the selection of the cultural variables to be included in the design and evaluation of treatment and prevention programs. Consequently, substance abuse researchers are beginning to tailor programs aimed at alcohol and other drug abuse problems for the cultural contexts in which those problems occur and, what is even more important, to determine the contexts in which those problems are best understood, treated, and prevented.

This chapter will discuss and illustrate methodological issues in conducting culturally sensitive alcohol abuse prevention research in ethnic-racial communities by citing the authors' own research experiences. Although the studies cited target Native American youth, the principles and skills drawn from these studies apply equally to work with other ethnic-racial groups, or with any other specific groups, including youths as a demographic group, persons with disabilities, older persons, and other particular populations. The chapter opens by considering the issues of cultural sensitivity and cultural competence. Next, we present in detail steps for achieving that sensitivity and competence. We then devote our attention to reviewing the application of culturally sensitive methodology in the practice of evaluating programs to prevent alcohol and other drug abuse.

Cultural Sensitivity and Cultural Competence

To borrow Marin's (1992) definition, a culturally appropriate intervention is a set of behavior-change strategies that is based on the cultural values of the target group, reflects their attitudes, expectancies, and norms regarding a particular behavior, and components reflect the target group's behavioral preferences and expectations. Intervention strategies that do not correspond to these cultural values may fail. Because some cultures abuse alcohol more than others, these considerations are particularly germane when investigating alcohol abuse, alcohol abuse patterns, and ways to prevent alcohol abuse.

No matter what their own ethnic-racial background, investigators must attend carefully to issues of cultural sensitivity if they wish to conduct culturally competent research. Investigators cannot assume they possess cultural sensitivity because they have the same ethnic-racial background as the target group; shared cultural identity does not guarantee facility in dealing with a particular group's day-to-day realities. Considerable diversity exists among the members of ethnic-racial groups, depending upon their geographic origin, income level, acculturation, religion, and other factors. There is no guarantee, for example, that a Navajo born and educated in Chicago would be culturally sensitive in work with Navajo farmers in Arizona.

Investigators from a wholly different culture may find it especially difficult to establish cultural sensitivity. But it is necessary. Moving across cultures—cross-cultural research—is unavoidable when conducting studies in today's society. In the United States, investigators can expect to work with a broad range of ethnic-racial groups, and within each group they will find significant diversity. In New York City, for example, Hispanic American can mean, in order of the proportion of the population represented, Puerto Rican, Dominican, Cuban, South American, and Mexican American. These groups of Hispanic Americans vary greatly, and culturally sensitive investigators will address each group with these variations in mind. Each

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target group is unique, and though it may share characteristics with other groups of the same ethnic-racial makeup, the investigator must develop sensitivity to that particular group and its members. Investigators should not assume that past experience or her or his own ethnic-racial identity will bridge the gap.

By definition, "cultural sensitivity" is an awareness of one's own and others' cultures. Another term used throughout this chapter is "cultural competence." According to Orlandi (1992), who is writing of the substance abuse prevention field, cultural competence includes cognitive and affective abilities that allow individuals to be knowledgeable, committed to change, and highly skilled at working constructively with members of an ethnic-racial minority group. Thus, cultural competence refers to a set of skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities. Whereas developing cultural sensitivity is a kind of consciousness raising, cultural competence requires learning the skills that facilitate working with a particular group in a way that leads toward constructive change.

Achieving Cultural Sensitivity and Cultural Competence

The great challenge for prevention researchers in the alcohol abuse field is to achieve not only cultural sensitivity but also the cultural competence required for the development and evaluation of responsive intervention programs and scientific investigations. To begin the process of achieving cultural competence, investigators should become familiar with the target culture. Reading about the culture, visiting, watching, and listening to members of the culture, and asking questions about the culture are all ways to increase familiarity with a target group. As investigators gather information, they must strive to remain descriptive, rather than judgmental, about the target culture. Maintaining objectivity is of the utmost importance.

Yet, despite the importance of thinking objectively and descriptively, research projects are not anthropological exercises. Investigators deliberately manipulate variables within the target

setting. Without the community's trust and approval, such manipulation may be met with suspicion or antagonism. Collaborating with members of the target community is therefore especially important in cross-cultural research. This collaboration is not superficial. Through it, the research team derives the insights, access, and credibility necessary for a successful study.

Ideally, investigators will gain the target culture's trust before initiating their involvement in the study. If members of the community believe in the integrity and sincerity of the project, they will be more likely to commit their time. With proper credentials, community members can collaborate in all levels of the research—as writers, co-principal investigators, project managers, interveners, and administrative aides. This collaboration can enhance a study's credibility. Working as peers with members of the community on a research project will also increase the likelihood of honest feedback. In our experience, when members of the community are on the project's payroll, they are more apt to invest themselves in and care about the integrity of the project.

Focus groups of community representatives may also enhance the cultural accuracy of the project and may reveal data necessary for proactive planning. Admittedly, focus group data can be imperfect. Random selection of a representative sample of community members will help guard against biased data, as will multiple sessions with different samples. Although investigators can never rely solely on focus group data, they should conduct focus groups during the developmental phase of a study and, ideally, also during the proposal writing phase.

Besides involving the community in the research project, the investigators should involve themselves directly in the life of the community. Investigators can learn a great deal through actively immersing themselves in the target culture. For example, while studying alcohol abuse prevention among Native Americans, investigators can take part, at least as observers, in spirit dancing, powwows, and other traditional ceremonies that will help them learn about this culture from the inside.

Optimally, investigators will verify at least some of their ideas with the target culture. Showing the study's variables and procedures to members of the community who have expertise

in the area may elicit valuable criticism. Feedback from collaborating members of the target culture will help investigators revise—to the extent that revision does not jeopardize the science—and investigators may then resubmit their work until consensus is achieved. This negotiation process can clarify the purposes of the research for the investigators as well as for the community. It will help to prevent misunderstandings and add depth to the study's content. Too much compromise on an intervention, however, will make it difficult to manage. Investigators will need to determine the extent to which the intervention can incorporate individual differences without losing its applicability. Indeed, investigators may find it necessary to sacrifice specificity and individual relevance to achieve generalizability to the larger community (Marin, 1992). Investigators, for example, may be forced to incorporate only those cultural values, attitudes, and norms that have shown intergroup variance and to disregard intragroup differences.

Although investigators are normally unprepared to establish a fully functioning alcohol abuse prevention program that will continue after the study is completed, a research project can offer other advantages for the community. There are economic benefits. Members of the community will be hired for the project staff, preferably in a field office (Schinke, Botvin, and Orlandi, 1991). A sense of ownership can be inspired by investigators who have made a sincere effort to involve the community. Toward that end, investigators can share materials from the study with as many community members as possible, and use traditional language from the community for curricula or other study materials (Schinke and Orlandi, 1991).

Culturally Sensitive Methodology in Practice

Many researchers have expertise in specific areas of their field and are eager to apply that expertise in new settings. Much of the time, such a process is mutually beneficial, but clinging to a research idea when it means disregarding community needs is often unproductive. The culturally competent investigator will

consider community needs and perspectives before adopting a research agenda. Such community input may alter the research focus. While that change may seem unsettling to the researcher, the benefits of conducting research that the community identifies as necessary are obvious. An intervention strategy that is perceived by the members of the target culture to be relevant and familiar is more likely to promote the behavior change being advocated than an irrelevant, foreign intervention strategy. The strategy that a community prefers, however, may be one an investigator knows to be relatively ineffective. Investigators should balance their responsiveness to the community with their own expertise in the area of inquiry. It is a delicate balance. During our work with the prevention of alcohol and other drug use among Native American youth, we have developed procedures for achieving this balance that may be useful with other target groups as well.

Recruitment and Training

In past alcohol preventive intervention studies with Native Americans, we have made use of two strategies to recruit community sites for research participation. Those studies developed and tested skills and family interventions to prevent alcohol abuse among Native American youth. In the first strategy, we conduct mass mailings to Native American community organizations and agency staff, including social workers, counselors, nurses, and allied human services and health professionals who are associated with alcohol prevention and treatment. Following the initial contact, we arrange for staff presentations, along with question-and-answer sessions on the nature of the study, the intervention approach, and agency staff responsibilities. If staff responds positively, we then seek administrative clearance from appropriate agency officials.

In the second recruitment strategy, we begin by contacting Native American community organization administrators to inform them of the study and obtain their participation. Once administrators agree to collaborate, the participation of their staff invariably follows. This second strategy is efficient and usually effective, though at times an enthusiastic administrator may

mandate the involvement of staff members who have little or no interest in the study.

These two strategies differ by whom we initially contact. In the first strategy, we contact and attempt to recruit staff who will presumably be involved in delivering the intervention (i.e., teachers, social workers). In the second strategy, we contact and attempt to receive from administrators or leaders of those staffs permission to recruit their staff. Although the first recruitment strategy offers some advantages, we found it less effective than the second when sampling a specific at-risk youth population. The difficulties we experienced in recruiting Native American staff without first obtaining the permission of tribal leaders made clear to us the merits of the second strategy. We have nevertheless capitalized in our research on the advantages of the first strategy by putting a premium on the voluntary support of individual staff, rather than relying solely upon administrative mandate.

Once the targeted Native American sites have agreed to participate in the study, our next step is to recruit specific personnel within the sites for intervention delivery positions. Research suggests that indigenous health education providers and slightly older peers are effective delivery agents of skills interventions (Botvin, et al., 1983; Hurd, et al., 1980; Luepker, et al., 1983; Murray and Perry, 1985).

Our studies have revealed both advantages and disadvantages in using peer leaders for alcohol preventive intervention delivery. Although in some cultures peer leaders enjoy higher credibility than professional staff regarding lifestyle issues, peer leaders lack the professional's skills in intervention delivery and management. Moreover, research with Native American youth populations reveals their preference for adults as leaders, thanks to the genuine respect for elders within the Native American culture. Yet other data suggest that slightly older peers are more effective than adults in presenting substance use prevention programs (Botvin, et al., 1990; Perry, 1989). To reconcile these various factors, we employ a combination of adult and peer leaders, with adult leaders as the primary delivery agents.

We conduct on-site community staff training in workshops led by our staff. Workshops orient Native American community

staff to our intervention rationale, describe intervention materials, provide a session-by-session analysis of interventions, and allow behavioral rehearsals of skills for delivering the intervention. In practice situations, community staff lead groups to simulate an intervention delivery experience. Besides providing staff members with substantive material, workshops generate enthusiasm and commitment among staff. Native Americans selected as peer leaders also attend training workshops conducted by our staff. Paralleling the on-site staff workshops, peer leader training provides an overview of the intervention, emphasizes rehearsals and practices, and allows time for discussion to clarify leader roles and responsibilities.

These staff training procedures have contributed to positive collaborative relationships between ourselves and the targeted Native American communities. In our own experience with developing and testing skills and family interventions to prevent alcohol abuse among youth, when members of the target culture act as intervention deliverers they are more likely to feel a sense of ownership toward the study. Using indigenous staff as delivery agents can also enhance the intervention's accessibility within the target culture (O'Sullivan and Lasso, 1992).

The intervention must be meaningful for the target community. In this case, because the intervention targeted alcohol abuse among Native Americans, recognizing drinking patterns unique to Native American culture was essential. Study variables should involve and reflect the target culture, and not be based solely on the norms of other ethnic/racial cultures or the majority culture. The language of the intervention must similarly reflect the language of the culture. The descriptors of our studies are modified with the guidance of the participating Native American community staff, to be meaningful to the target culture in all phases of the intervention.

Yet despite such cultural specificity, maintaining generalizability is also important. If a study is too specific, so that it pertains to only one tribe living in one area, the experiences and results attained from the study will not be of help to other tribes with similar needs or to other researchers seeking to benefit from the work of prior studies.

Study Approach

In the first year, working with members of our target Native American communities, we develop study interventions to prevent alcohol and other drug abuse among the youth. Once we have a draft version of study curricula, we conduct multiple focus groups, one with a random sample of Native American youth counselors, another of youths, and a third of their parents. These focus groups examine study interventions for their cultural responsiveness, interest, and logistics. Focus group feedback helps us to test and revise study interventions. We continually improve the interventions until focus group data indicate that each intervention is ready for field testing. Native American staff from the community assist with the conducting, recording, and interpretation of focus groups.

To maximize the effectiveness of the interventions, we have employed a combination of our own staff, Native American agency providers, and slightly older peers. As primary intervention providers, staff employed by collaborating Native American community organizations can help to supply focus groups with subjects, organize intervention activities, help youths in identifying appropriate goals for preventive intervention, provide youths with positive reinforcement, organize behavior rehearsals, maintain order, and coordinate peer leaders' activities. Native American peer leaders can serve as discussion leaders and role models, demonstrate behavioral skills, and organize role-playing sessions.

Most intervention studies require a no-intervention control group. In some communities, such a group may be considered unacceptable or unethical, particularly in an alcohol and other drug abuse prevention program. Ethnic/racial groups who feel exploited by the majority culture may interpret an outside investigation as invasive, or as a detached laboratory experiment to satisfy the institution's curiosity rather than to help their community. This distrust can increase when they learn that some members of their culture who participate in the research will receive no intervention. Our research with Native American people has sensitized us to their problems with no-intervention and control

groups. Unless we are persuaded that such groups are essential, we are reluctant to randomly assign Native Americans to an arm of the study that we know will not provide an effective intervention. Yet, despite this community pressure, conducting an intervention without the proper scientific conditions renders the study meaningless. We typically offer control condition subjects either a different, unrelated intervention or—once we have completed the formal study period—the same intervention that the other groups have received. The control condition subjects become members of what we call the wait-list control group. In these arrangements, as in any arrangement a researcher may work out, what is essential is the right balance between scientific needs and goals and the target culture's concerns.

Some studies can avoid using a no-treatment control group altogether. Studies that are refining or testing existing interventions may use comparison groups that are themselves exposed to some intervention instead of using no-intervention control groups. For example, in a study aimed at reducing substance abuse risks among Native American adolescents through an interactive computer intervention, we used a randomized clinical trial design with repeated measures. Subjects in one group received the intervention via interactive computer, and subjects in the second group received the same material in a group intervention. Although the absence of a nonintervention control arm precluded comparisons of either intervention against no intervention, the design allowed the testing of the relative merits of two intervention strategies.

Such a design is feasible when investigators have empirical reason to believe that any intervention is preferable to no intervention—based on prior research data, for example—and when statistical power calculations indicate that the design will permit the discovery of relatively small differences between groups that received variations on the same intervention.

A related concern in cross-cultural research is the issue of randomization. True experimental designs require a random sampling of the community for study participation. As a result, some of the community will not take part in the study at all, or may not receive intervention. Community members who are

unaware of the reasons for randomization in scientific studies may object to their exclusion from the study. At the very outset, investigators must explain clearly to the target community what they can and cannot expect from the planned study. These matters have to be spelled out in detail and should be repeated more than once. We have also found it helpful to point out to control group members the benefits of participating in the research despite their not receiving intervention. These benefits include contributing to the prevention of alcohol abuse among Native Americans, and discovering their own risks for alcohol abuse. In our own experience conducting prevention research with Native American populations, we have been successful with randomization.

Measurement

Selecting sound measurement instruments is frequently problematic when working with ethnic-racial communities. Most measures that exist for study phenomena are not sensitive to particular ethnic-racial or other cultural groups. Few good options exist for resolving this dilemma. Using a widely accepted measure that does not have normative data on the target group is one option; developing a new measure is another. Developing a culturally sensitive measurement, however, can comprise a research project on its own—unless the investigator proposes time in the study for that process.

In our own research experiences, we have formatively and psychometrically tested outcome measurement instruments for use in quantifying the effects of alcohol abuse prevention programs with specific cultural groups. Formative testing with focus groups of target subjects refines and adds precision to each measurement instrument and scale. Unquestionably, focus group data can be marred by participants' biases. Investigators too can prejudice focus group data by asking leading questions. Conducting multiple sessions with a random selection of community participants helps guard against biases.

Content for focus groups comes from our own and others' questionnaires on alcohol abuse and related behavioral risks.

Addressing issues of age-, gender-, and cultural-responsiveness, focus groups involve subjects representing both genders, substantial ethnic-racial and majority culture groups, and urban and suburban settings within the study region. Leaders of measurement focus groups follow guidelines for convening, executing, and recording the sessions (Krueger, 1988). Guided by conventional procedures, we analyze and interpret focus group data (Patton, 1980).

Once focus group data have informed changes to the format, ordering, and language of each instrument, we psychometrically test the measures. Psychometric tests involve stratified samples of another group of subjects from each gender, and majority culture group (if relevant), and urban and suburban community site. Psychometric tests determine the reliability of each instrument and scale through test-retest and split-half procedures. Whenever feasible, we cross-validate our measures' scores with data from parallel instruments. For example, data from a new or adapted measure can be compared with findings from extant measures on the same variables.

Ownership

In a study to prevent alcohol and other drug use among Native Americans in the Pacific Northwest, we used the name "La Quee Biel" as the title of the curricula. "La Quee Biel" means to cure or to prevent in the Coast Salish language. Based on our conversations with community members, it was our impression that titling the curricula with the study culture's language helped to build a sense of ownership among the community.

When the alcohol and other drug abuse prevention project expired, we left behind tangible goods for the community. Community treatment manuals, curricula, posters, videotapes, and T-shirts, together with articles reporting the results of the study, were made available to the community. As a result of the positive findings from the intervention, some Native American field staff recruited from within the target reservations were eager to continue using the materials. Their three years of experience delivering the intervention to prevent alcohol and other drug use gave them the necessary experience to continue doing so. Other Native

American staff had learned through our study relatively sophisticated data gathering and data entry procedures. Two of these staff were able to obtain data entry jobs with other local research efforts.

We were fortunate to have developed and maintained a good relationship with the target community in the above study. Certainly, we owe some of that success to our commitment to involving the Native American community in the study to the greatest extent possible. Other investigators can achieve harmonious relationships with communities by similarly encouraging community ownership. Investigators should, however, beware of promising anything to a community before they are absolutely certain that the promise can be kept.

Possible Risks

Establishing cultural competence is difficult, but the rewards for attempting to meet the challenge, however imperfectly, are great. Investigators who develop proposals, ideas, interventions, measurement instruments, and sampling procedures that are culturally sensitive and culturally competent set themselves apart from their peers. It will often be necessary to strike a compromise between a study's cultural responsiveness and its scientific integrity. Cultural responsiveness may be particularly necessary because of the need to attract, engage, and impact members of an ethnic-racial group who have not been responsive to interventions in the past. But without a rigorous design and evaluation strategy, even the most promising prevention program cannot be found effective and therefore recommended for programmatic use.

An honest presentation of the reasons for a particular compromise in the study proposal will allow reviewers to follow the investigators' decision-making process. Such evidence that decisions have been carefully considered can be persuasive to reviewers. Proposals that lack cultural sensitivity and cultural competence are not likely to receive funding. What is more important, intervention programs that lack such sensitivity and competence may be less effective in reducing alcohol abuse (Moskowitz, 1989; Marin, 1992; Flay, 1986).

Despite the benefits of conducting culturally sensitive research, investigators devoted to such research expose themselves to risks. Some ethnic-racial groups may view the investigators as opportunists. Target group members may suppose that the investigator's interest in them is prompted by the need for funding rather than by a sincere desire to improve the community's well-being. At times, it may be appropriate to say to members of the target group that, while naturally the investigators have an interest in getting financial support, funding for the project will mean that the community has a real opportunity for education and change.

It is also possible for the community to misinterpret the purpose of the research. Some members may confuse research with actual service delivery. This can lead to trouble when the research project expires, as well as during the project's course. Carefully reviewing the grant proposal with key community figures can guard against this misconception.

Other risks concern letters of collaboration. Some communities may consider a request for their letter of collaboration as tantamount to the receipt of a grant. Community leaders may spend considerable time weighing their response to the investigator's request without understanding that their willingness to collaborate does not guarantee that the research project will be funded. Wise investigators will make it very clear to the target group what the letter of collaboration is and what it is not. They may thereby lessen ill-feeling in a disappointed community if the project is not funded.

As with all research programs, the limited success or outright failure of an alcohol abuse prevention program for members of an ethnic-racial group entails risks. If the program fails to do what was hoped for, the investigator will, at the least, be made to feel embarrassed. Of more serious concern, a lack of positive findings may lower the investigator's status within the target culture and leave members of that culture hesitant to participate in other studies. Individuals may lose their faith in research programs altogether if even a study that has been carefully tailored to their particular culture yields no tangible results.

Conclusion

This chapter deals with methodological issues in conducting culturally sensitive alcohol abuse prevention research in ethnic-racial communities. The chapter reviews issues of cultural sensitivity and cultural competence and proposes steps to achieve such sensitivity and competence. Most of the chapter is concerned with procedures for implementing culturally sensitive methodology in evaluating programs to prevent alcohol and other drug abuse among cultural groups. Despite the chapter's emphasis on substance abuse prevention research among Native American youth, the principles and skills illustrated by that research apply to research with other ethnic-racial groups and with other culturally defined groups as well.

Conducting culturally sensitive research has several benefits. It can be more relevant, meaningful, and important than research that pays only cursory attention to cultural nuance. Researchers who sensitively and accurately assess cultural variables can have greater confidence that study results were due to the intervention itself. Conversely, researchers whose methods ignore or minimize cultural issues may reach erroneous conclusions.

In the United States today, there are thousands of individual cultural groups, with many more groups—and increasingly heterogeneous ones—nascent as the country's population grows and diversifies. Notions of culture and of cultural groups are changing rapidly as population demographics shift. Soon, for example, ethnic-racial groups that once comprised segments will gain dominance in population percentages and numbers. Because patterns of alcohol use and other substance use will continue to vary by cultural group, investigators no longer have the option of developing universally applicable methods for building, testing, and disseminating preventive intervention strategies. To avoid the implications of cultural variables is to suffer the consequences of investigations that neither address those variables nor impact positively the target population.

This chapter is a first step in helping investigators not only to understand the nature of cultural variables in research design, but also to respond to cultural issues with predictably sensitive

and effective designs, methods, and procedures. Once we achieve that predictability, we greatly increase the likelihood of moving the field of alcohol abuse prevention forward by creating and building upon solid empirical data that realistically reflect the everyday context of the groups we are targeting. To engage in that planful forward movement is to further the scientific process that has so successfully laid the foundation upon which the field of prevention is building. Perhaps the guidelines offered in this chapter will in some measure promote the application of tested scientific principles in future efforts to investigate alcohol abuse prevention programs within a cultural context.

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Methods to Create and Sustain Cross-Cultural Prevention Research Partnerships: The NAPPASA Project's American Indian— Anglo American Example

Jon Rolf

Introduction

Community-based prevention research with youth in high-risk environments is a very complex undertaking. It often requires a collaborative multi-disciplinary project team in order to develop, implement, and evaluate its preventive interventions. Unfortunately, prevention researchers are rarely members of the communities in which they conduct prevention programs for at-risk

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youth. This is especially the case for some racial-ethnic communities which have great need but do not have residents with all the requisite methodological skills to conduct prevention studies. It is possible for these communities to form productive prevention research partnerships with researchers from outside the community when the expected benefits clearly outweigh the risks of working with them. However, the research partnerships will fail if the outsiders are perceived to be culturally insensitive to local values, customs, and politics or whose short-term research agenda seems to take away more than it gives to the community.

Prevention researchers who choose to work in a racial-ethnic community in which they do not live or share ethnic identities have unique lessons to share, given that no two communities have identical needs for prevention programming. This chapter describes the experiences of a prevention researcher who was invited to come into a racial-ethnic community in order to develop a new prevention project. It came to be known as the Native American Prevention Project on AIDS and Substance Abuse (NAPPASA), and the experience gained from forming prevention research partnerships with American Indian communities in the Southwest is the substance of this report. Drawing on his personal experiences¹, the author identifies several lessons and issues which help explain how the NAPPASA project's research partnerships were made and became productive.

These thematic issues are:

- Finding local leadership
- Telling the project's origin story
- Why us?—Why you?
- Giving more than getting
- Listening to what they have to say
- Being there
- Telling the prevention story through local media

Before describing each of these in detail, some background information should be provided concerning: (1) the project's American Indian community contexts in Arizona relevant to risks for alcohol problems and HIV infections, (2) the prevention needs of these American Indian communities, and (3) an overview of the NAPPASA project's research design and programs.

An Overview of the Northern Arizona American Indian Populations and Some of their Prevention Needs

Were the author an American Indian, he might describe the American Indian communities in northern Arizona with different words than are used here. Were he Navajo, the words about this tribe and its health needs would certainly be different. Instead, the prose of an Anglo-American academic prevention researcher is used here to present background data used to justify the choice of research partners and the communities' motivations to seek such partnerships.

The NAPPASA project has been developed with a number of American Indian and ethnically mixed communities in northern Arizona. Most work has been with Navajo communities. The Navajo Nation is one of the principal tribes of American Indians now residing in northern Arizona. Other local tribes include the Hopi, Southern Paiute, Havasupai, Walapai, White Mountain and Yavapai Apache, and the Yavapai. Most live on reservations, and the Hopi reservation is even embedded within the lands of the Navajo Reservation. The Navajo are the most numerous locally, and the Navajo Nation is also one of the two largest tribes in the United States. Its members comprise about one fifth of the United States American Indian population. Most Navajo (about 160,000 to 180,000) live on their reservation, which occupies 25,000 square miles of northern Arizona, northwestern New Mexico, and southern Utah. Many other Navajo and persons from other tribes live in border towns adjacent to the reservation (Coulehan, et al., 1983). It is estimated that 65,000 Navajo live outside the reservation in adjacent border towns such as Flagstaff and Winslow, Arizona, as well as in distant cities such as Los Angeles and Phoenix.

Navajo traditional culture involves pastoralism and living in scattered homesteads rather than large groups. Even today, a great many Navajo live in solitary or clustered traditional homesteads across their reservation. However, Navajo philosophy embraces change wherever it can be incorporated into Navajo tradition. Consequently, in recent decades the Navajo have

accepted all kinds of new employment patterns and lifestyles, even while maintaining strong linguistic and cultural traditions. Many of the Navajo living on or near the Navajo Nation Reservation are bilingual. For a great many of the Navajo, their first language was Navajo or a mixture of Navajo and English. On and near the Navajo Reservation, Navajo is a very common language of daily discourse, although English is the primary language of instruction in the schools.

Local Factors Which Impact Health. Important socioeconomic factors (including poverty, unemployment) and geographic conditions (extreme rurality and distances between towns and health services) influence the health behavior of the Navajo, other American Indians and non-American Indians living in northern Arizona. Some of these factors can place certain sub-groups in the population at high risk for injury and disease. Among persons at risk are those who use or abuse alcohol and other drugs (AOD). These higher risk persons and other northern Arizona residents typically make long trips to towns across or bordering the reservation in order to access various commercial outlets, community services, and recreation facilities. On these long trips (often as drivers or passengers in the open truck beds of pickups), there are very high risks for traffic accidents. (In fact, recent reports (Caces, et al., 1992) show that alcohol-related mortality rates locally are among the highest in the United States.) For some people, these trips are also occasions for misuse of AOD. Under these conditions the traffic accidents are even more likely, as is the case for alcohol-related violence and opportunities for intimate contact with sexually transmitted diseases (STDs) and HIV carriers through unprotected sexual behavior. Local health service providers were very aware of such alcohol- and drug-related problems and mortality, and they were very receptive to developing new prevention partnerships which might address these risks.

Northern Arizona's rural American Indian communities are not isolated from health problems such as HIV/AIDS and abuse of injected drugs, which are usually thought to be mostly confined to urban areas. Northern Arizona's only methadone maintenance clinic and its attendant population of injecting drug

users (IDUs) is located in Flagstaff, Arizona, which is the major commercial center serving the NAPPASA project's communities. These IDUs probably represented one of the earliest vectors for HIV transmission to local American Indian populations through the sharing of injecting needles and through sexual intercourse. In addition, the risks for HIV-transmitting sexual contacts with non-IDUs is heightened by a number of other geographic and economic factors in northern Arizona. Seasonal tourism is booming, with tens of thousands of outsiders visiting the nearby Grand Canyon and attractions on the reservation. Many other outsiders pass through northern Arizona due to Interstate Highway 40's long-haul trucking depots, the Santa Fe Railroad's depots, and the Winslow, Arizona, prison's practice of holding in-transit extradited criminals in cells with local prisoners. Furthermore, northern Arizona American Indian residents are faced with high unemployment rates (as high as 40–50% for the Navajo; Yates, 1987). This compels many Indian adolescents and adults to seek work in other cities such as in Southern Arizona, Texas, and California.

In these cities the available low-paying jobs may limit them to living in urban locations where substance abuse and rates of HIV infection are much more prevalent (Coulehan, et al., 1983; May, 1986; Weibel-Orlando, 1987). Since ties to family and the reservation remain very strong, most of these dispersed workers return home several times a year for traditional ceremonies, recreation, and procreation, during which time HIV infections might be inadvertently brought back to local residents.

Alcohol Morbidity and Mortality. Because the Navajo are a very large tribe with many contacts with the United States Indian Health Service (IHS) clinics and with tribal health services, considerable data about AOD use and abuse have been generated for study. These data show that alcohol abuse is an extensive problem requiring treatment and prevention programs (e.g., Andre, 1979; Bach and Bornstein, 1981; Topper, 1985; May, 1989, 1986; May, Hymbaugh, Aase, and Samet, 1983). Age-adjusted alcohol-related morbidity and mortality rates among the Navajo far exceed rates for the general United States population: rates are fourfold higher for alcohol-related injuries, almost twofold

for violence, almost threefold for alcohol-related illnesses, and twentyfold for alcohol-related deaths (Broudy and May, 1983; USIHS, 1984; Yates, 1987; May and Hymbaugh, 1989). May (1986) reports that the rates of indications of alcohol-related problems are also high. These indicators include arrests, suicides, and cases of fetal alcohol syndrome. Age-adjusted suicide (per 100,000) rates for calendar year 1987 are: 11.7 U.S. all races, 18.6 all IHS areas, 14.7 IHS Navajo area (see USIHS, 1991).

Prevention Orientation of Local American Indian Communities. A recent report on the health-risking behaviors and health problems of American Indians and Alaskan Natives presents data that suggest that American Indian youth have a great need for prevention programs (Blum, et al., 1992). These authors reinforced the pre-existing belief that there is also a great need for culturally and behaviorally oriented studies to discover modifiable AOD abuse risk factors that would respond to preventive interventions. For example, there is need for new prevention programs to test interventions which can influence the factors determining why some Indian youth within certain contexts abstain from alcohol, some become binge drinkers, and others become chronic heavy drinkers.

A number of researchers have done considerable work with the Navajo and other American Indian tribes to try to understand how alcohol-related problems are moderated by a range of socio-economic and cultural factors (e.g., Andre, 1979; Beauvais, et al., 1985; May, 1989; Fleming, et al., 1989). AOD abuse has been associated with considerable stress, feelings of powerlessness, and acculturation pressure and depression (Manson, et al., 1985). Some social scientists have suggested that, for some American Indians, AOD use may represent a political or symbolic resistance to the dominant White culture (Schinke, Gilchrist, et al., 1985; Schinke, Schilling, et al., 1985). For some American Indian youth, alcohol and other drug abuse may be related to a lack of strong integration into either modern or traditional society (May, 1986); for many youth, AOD use is congruent with perceptions of existing peer norms (Oetting, et al., 1980, 1988). These research findings suggest that some youth do not always regard existing local norms of AOD use as indicating inappropriate or deviant

behavior, even though high rates of AOD use in youth and adults consistently alarm tribal elders.

In sum, as with many other ethnic subgroups in the United States, AOD misuse and abuse are highly complex phenomena in American Indian communities, with AOD abuse influenced by a host of factors (May, 1986; Heath, 1985; Gilchrist, et al., 1987). Many of these risk factors should be modifiable through culturally and developmentally appropriate preventive interventions. One could document the prevention needs of American Indians. However, in proposing the NAPPASA prevention research project to NIAAA, it was not sufficient to argue that the descriptive literature demonstrated great need. It was essential also to show that there really was considerable evidence of strong community commitments for developing potent and enduring programs for AOD abuse treatment, needs assessment capabilities, and AOD abuse prevention.

Overview of the NAPPASA Research Project

The Native American Prevention Project against AIDS and Substance Abuse (NAPPASA) is a multicultural, in-school, and community outreach AIDS and alcohol and other drug abuse (AODA) prevention program. NAPPASA is funded by the NIAAA Prevention Research Branch. Its research mission is to collaborate with American Indian and neighboring communities to plan, develop, implement, evaluate, and disseminate culturally sensitive HIV / AIDS preventive interventions linked to AOD abuse prevention programs. NAPPASA's prevention goals go beyond improving knowledge and changing attitudes, for its programs are designed to: (1) change risky behaviors into health-protecting ones at the individual level, and (2) change community awareness of local health problems and risks into active participation in prevention programs.

All of NAPPASA's programs were expected to be (and have in fact been) developed through partnerships with local educational, health, and other community-based organizations. NAPPASA's staff and community partners strive to identify common

goals and values across cultures in order to further promote the project's guiding principle, "To Promote Health and Harmony by Sharing Knowledge." NAPPASA's program materials (prevention curricula, media, training guidebooks) are also produced and disseminated by the partnership in ways to meet standards of both academic research and local customs and values.

Research Questions. The research protocol addresses six broad questions: (1) Will linkage of HIV/AIDS and alcohol and other drug (AOD) prevention themes prove reinforcing to each other and strengthen motivations for prevention among residents of the participating American Indian communities? (2) To what extent can culturally sensitive ways be found to fit the local cultural value systems and learning styles with a public health oriented Social Action Theory (SAT) multimethod approach to prevention programming? (3) How much will the project's experimental school interventions significantly change existing HIV/AIDS and AOD knowledge, attitudes, and behaviors? (4) Will the project's community outreach and media interventions enhance and sustain the school interventions and the NAPPASA research partnerships? (5) How much will NAPPASA's locally produced videos and print media increase program impact and community acceptance? and (6) How well will the core NAPPASA prevention intervention programs replicate across schools in Navajo, other American Indian, and ethnically mixed communities?

Project Design. The NAPPASA project is designed to conduct and evaluate three years of field trials of a school preventive intervention program based on social action theory. The school programs are supported by a community outreach health education program. Therefore, the in-school prevention curriculum and supporting after-school activities emphasize ways in which American Indian youth can build protective skills and self-efficacy beliefs. More specifically, the school-based intervention program is conducted as a series of quasi-experiments involving within and between school comparisons with annual cohorts of 8th and 9th graders. There is a separate intervention curriculum for each grade. Therefore, the school prevention program is a two-year sequence, with the 8th grade junior high Stage 1 curriculum given first and then reinforced the following year by the 9th grade Stage 2 curriculum.

Each of the NAPPASA prevention curricula is implemented with standard procedures which include: (1) standard instructor training, (2) culturally sensitive and developmentally relevant Instructor's Manuals and Student Manuals, and (3) reliable and locally validated baseline, post-intervention, and follow-up evaluation instruments. Pairs of instructors conduct the curriculum in each classroom, and the qualities of their performances are monitored by standard process evaluation procedures. Each curriculum version (i.e., the 8th grader's Stage 1 and the 9th grader's Stage 2 is structured with twenty-four 50-minute scripted class sessions designed to build knowledge, personal skills and peer group norms for preventive communications and behaviors in the context of American Indian health beliefs and values. Additional "booster" interventions are administered after an interval of several months. Informed consents for student participation in the prevention curricula are obtained from the community and school boards, from parents, and from the students themselves. School program assessments involve non-anonymous pretest, posttest, and 5-month and 12-month follow-up student questionnaire evaluations. Both outcome and process evaluations are conducted.

Outcome evaluations for the school-based interventions include assessing the Social Action Theory prevention model's antecedent and mediating processes hypothesized to influence future rates of AOD use, HIV/STD-risking sexual behaviors, and the practice of new health-promoting habits (Baldwin, et al., 1993).

Process evaluations are also undertaken at key times to: (a) detect barriers to program implementation, (b) measure the fidelity of application of the standard curriculum implementation, and (c) document the extent of student and community satisfaction with and cultural relevance of the preventive programs.² For the current discussion about conducting research in racial-ethnic communities, what is especially relevant about the NAPPASA project is its *scope* (both 8th graders in junior high and 9th graders in senior high at-risk youth, multiple schools and communities), its *targets* (individuals and institutions), its prevention *topics* (values, sex, alcohol, drugs, etc.), and its *poten-*

tial for inadvertently creating a program component that would be incompatible with some aspects of local customs and family values. Therefore, it was essential for the NAPPASA project's research team to develop functional partnerships with members of the project's host communities to ensure that the new prevention programs would fit well with local contexts.

Methods Used in Adapting NAPPASA'S Prevention Science to Fit with Local Community Contexts

Clearly, the NAPPASA prevention project touched on a number of sensitive areas in its host communities as its programs were developed and tested. Further, some research-oriented outsiders were asking to make partnerships across conventional institutional and cultural boundaries to effect a complex prevention program at multiple levels of community life. Specifically, the project was asking to introduce AIDS prevention for youth as an urgent health concern before it was recognized as a real threat to local American Indian youth and adults. Further, the project approached both AOD abuse and HIV/AIDS as behaviorally transmitted epidemics. Thus, the schools were asked not only to consider providing class time but also to help design and implement a preventive education program specifically targeting HIV/AIDS and STD risk reduction. Given that almost no sex education topics or courses had been attempted before in most of the potential host schools, the proposed NAPPASA project needed considerable "up-front" trust and political risk-taking by school boards and administrators.

One more issue complicated the project's entry into community life. The project began partnership negotiations during the time when major campaigning for reservation-wide elections was under way. Therefore, when the project team arrived in northern Arizona, each community was engaged in choosing candidates to support for tribal chairman, tribal council representatives, local chapter representatives, and—perhaps especially—

for local school boards. In sum, this was a time of important changes in the social and political climates of the host communities. Fortunately, initial concerns that the federally funded NAPPASA prevention project could become a political issue proved to be unfounded. NAPPASA did not get politicized even though it was asking for some courageous decision-making about a very difficult kind of health promotion and disease prevention program.

NAPPASA's discovery of a potentially sensitive mixture of prevention topics, targets, politicized groups, and local community history is not an uncommon situation for prevention researchers desiring to come to racial-ethnic communities in order to form new research partnerships. Whenever possible, ample time should be provided in the project's time frame to discover harmonious ways to work together toward common prevention goals. With the NAPPASA project, a specific mixture of activities was undertaken to cope with the challenging issues and potential barriers encountered in working with its host reservation and border town communities. In fact, these activities defined much of the scope of work during the project's first year. During this first and subsequent years, the research team came to perceive several underlying themes and issues (described below) which had to be addressed regularly to ensure that the researcher-community partnerships remained functional and truly collaborative.

Themes in Making NAPPASA's Prevention Partnerships Functional

Effecting Local Leadership

The most important initial tasks for the academic research team were to recruit and hire two local project leaders to serve as the On-Site Project Director and the Coordinator of Community Programs. The On-Site Project Director³ was chosen for her prevention research expertise. Given that she had American Indian ancestry but was not a member of one of the local tribes, it was very important that the NAPPASA project find a local Navajo

person for the position of Coordinator of Community Programs, as the research team was working in predominantly Navajo communities or those bordering the Navajo Reservation. The project was fortunate to recruit for the Community Program Coordinator a culturally traditional woman⁴, fluent in both Navajo and English, who was well known to the local education and health services networks. She has filled an essential role by being the local project leader who remained most focused on keeping the program both relevant and sensitive to traditional cultural and community concerns even if her Anglo-American academic research colleagues failed to understand important subtleties in these areas.

As will be discussed below, the issue of "Being There" to work on the reservation and being from the reservation communities was a critically important issue in building the long-term prevention partnerships with local people. The project would have taken a serious misstep had it not chosen a local Navajo person as its community program coordinator, or had its On-Site Project Director not chosen to live part time in one of the reservation communities.

Building From Local Initiative by Telling the Origin Story

This was a very important task for the project leadership during its first year. As is the case for the gatekeepers in any community who are being asked to form a research partnership with outsiders, the NAPPASA project's Navajo community gatekeepers wanted to understand several things up front:

- What did the project's researchers propose to do?
- Why should they do it in or near the reservation communities?

The project's origin story answered these two key questions. In brief, the NAPPASA project's origin story told how the principal investigator (J. Rolf) was invited to come to Arizona. The invitation arose when a local Navajo community (Leupp) school board came to Johns Hopkins University to inquire about the HIV/AIDS epidemic's potential threats to Navajo adults and

youth. After meeting with the author (Jon Rolf), the board decided that the AIDS threat could become a real one to their own community and that this threat might grow larger with time. Therefore, the school board asked the author if he would come out to Arizona and help them plan an AIDS prevention program for their school. When he responded that he only knew something about HIV/AIDS prevention but not about Navajo people, the Navajo members of the school board laughed and said, "You help with the AIDS part and we'll take care of the Navajo part."

Telling how local initiative was involved in the NAPPASA origin story was an essential step in establishing the project's legitimacy: namely, *the public health researchers were invited by a local school to come and work with them*. Another question answered by the origin story concerned the NAPPASA project's funding. Because there was no local funding for such a program, the author was encouraged by the local communities and schools to seek funds through writing prevention research grant proposals. When the research funding was obtained, the author returned to Arizona to tell how the NIAAA Prevention Research Branch saw the merits of funding a joint AOD abuse and HIV/AIDS project conducted by Johns Hopkins faculty in partnership with educators and health service providers from American Indian communities in northern Arizona. Because the project's origin story involved local initiatives and had brought new external funding, the community people were ready to ask the next questions: "Why us? And why you?"

Justifying the Cross-Cultural Partnership by Answering Why Us? And Why You?

These questions are always asked of prevention researchers who come from outside a racial-ethnic community to start a new program. For the Navajo communities' gatekeepers, these questions may have been particularly important for several reasons related to their tribe's historic relationships with White men and women. Several probes were often added to their basic question—"Why You?" These were:

- Why are you, another Anglo from around Washington, D.C., coming to our reservation expecting us to want to be a part of *your* health program?
- Why should we want to help another Anglo researcher, because some
- of you researcher people have previously only taken from us and never given us things of lasting usefulness?"

There are a number of levels of communication in these questions. Some of them are a normal part of negotiating contracts and partnerships. In addition, there was a special emotionally charged concern that needed to be laid to rest before the NAPPASA project could begin. This concerned "Why Us—Why the Navajo?" The academic public health research team told the community they had come only because they had been asked by some local people. Finally, the academics acknowledged that they had been made aware of the local prevalence of AOD abuse and interest of community leaders in creating new prevention programs through partnerships. However, it was also very important to explain that the research team had not come to Arizona's American Indian communities because the researchers thought them to be "worse" or more in need than where they themselves had come from. Instead, it would be "up to us, *together*," to prove that the new prevention programs created in partnership could make a difference in the rates of future problems right here in Navajo land. These explanations seemed to help clear some tensions about "Why Us—The Navajo?"

With regard to "Why You—the Johns Hopkins Researchers?" the community people seemed to respect the fact that the prevention researchers had previous experience developing prevention programs for their own home communities and for other racial-ethnic communities that had invited their help. It was important that the researchers were willing to do the kind of work in Arizona that was valued in their home communities and elsewhere. What the Johns Hopkins team did not fully realize then was that their explanations may not have addressed some local individuals' expectations that the unspoken research goal was to study the worn-out stereotype of "drunken Indians." Therefore, in some meetings, it was important for the research

team to specifically distance itself from this particularly noxious stereotyping.

The NAPPASA prevention researchers were also prepared to negotiate and somehow demonstrate the understanding that all parties could and must find highly visible ways to share power, resources, and values to start the prevention partnership and to avoid an ongoing "US vs YOU" power struggle. To be an effective leader in the NAPPASA project required the ability to cope with many seemingly conflicting cultural, political, fiscal, managerial and scientific issues. What was unique for the author in negotiating partnerships with local Navajo communities was the experiencing of a different kind of racial tension (i.e., Indian vs. Anglo) combined with a prevalent, pre-existing attitude involving willingness among some local community persons to express overt rejection of all research projects in general (i.e., "All research is bad for the community").

Part of this difference in perceived cross-cultural tensions may be due to several facts. First, the reservation communities are located on separate sovereign nation states within the United States. Second, these sovereign Indian Nations are frequently in court fighting against various programs controlled by the State or Federal governments or private non-Indian corporations. The Johns Hopkins scientists had to come to understand these facts. Looking back, the author now believes that he was handicapped in partnership negotiations because he had grown up in environments where he had seen no Indian-Anglo hostilities. The author did not know how to confront these historic hostilities and the undercurrents of racial prejudices. The author missed some signals when local people expected him either to reveal or to disavow the expected enemy Anglo role.

For example, as Anglo-Americans wanting to work in Indian country, the author and the other academic researchers had to learn and to accept that some potential partners (and some American Indian project staff) would expect them to be truly prejudiced against American Indians. They expected that this prejudice would be expressed both overtly and subtly in the project's research goals, in project staff hiring, in sharing control of the project's agenda, and especially in the taking of data from the

participants. The principal investigator especially had to learn to confront stereotypic expectations that he would prove to be secretly, deep down, prejudiced against Indians; that he might be, deep down, not really committed to serving the prevention needs of local communities; or that he would be covertly trying to "take more than he would give."

For the author, there were two distinct phases to confronting community expectations of anti-Indian prejudice. The first stage was to show that he would not take it personally; that is, to accept the legitimacy of the historic distrust of Anglos while explaining why *he* would be an exception to the rule. The second stage was harder for him to accept, for he had to discover and to define his personal limits to being stereotyped as anti-Indian simply because he is Anglo. Discovering these limits, he had to start taking very personally local persons' attributions that he was expected to be anti-Indian. This stage was reached probably because there were some NAPPASA partners who very much wanted the project to work and who hoped to be extremely committed to its goals. For them, the project was potentially very important to *their* people, and therefore they most feared the project's potential for doing their people real harm if the project's leaders had false faces. In their logic, were they to support this powerfully important project and the principal investigator's leadership as an outside researcher, they too might become enemies of their people if the project had false goals.

For the author and other non-American Indian researchers on the NAPPASA project, "taking it personally" meant being ready to tell how one's personal values, long-standing commitments to public health, and dedication to seeing the collaborative project through deserved more than stereotypic suspicions and hostility. The bottom line was this: "There has been bad history, but there can be a new positive history in prevention working with this team of Johns Hopkins public health scientists. Believe it, work with it, or leave the project partnership." In retrospect, the NAPPASA project experience taught important lessons to its outsider researchers about how everyone must expect to check their real values and motives and to *emphatically* declare them in order to become true partners with community partners. Such

declarations may be most necessary to give to those who may have the most to offer the project in return.

Effecting a Long-Term Prevention Agenda by Giving More Than Getting

"Researchers always take too much and give too little" was another common concern voiced in NAPPASA's host communities, and this concern has been voiced in other prevention projects (e.g., Fawcett, 1991). In negotiating the NAPPASA project partnerships, the research team repeatedly heard from different community groups how no one was interested in "one-shot" programs. When it was explained that the NAPPASA project was designed to provide four years of new school and community programs, the rejoinder often was: "But four years is not very long." In response to this issue about the project's intentions to make long-term investments in the community, several additional commitments were emphasized by the project's researchers. These were:

- the project is investing in a wide range of community consultants and staff to ensure that our prevention program products fit into and can be sustained by the community's institutions and value system;
- The project is training the local schools' regular teachers and co-instructors (recruited from the community) to implement the program; they would still be in the communities to use their new knowledge and skills even after the outsiders leave; and
- The researchers on the project are helping write new grants to continue the prevention programs if the program evaluations proved them to be effective. The project has followed through on each of these commitments to long-term investments.

With regard to the issue of not taking more than they give, the outsider researchers on the NAPPASA project's research team sometimes had to prove that they were not working in Arizona simply to further their careers. This issue arose when community gatekeepers voiced suspicions that the researchers'

motivations for doing the program were primarily to: (1) advance themselves via gathering data for publications which would lead to fame and promotion, (2) use grant staffing funds for external instead of community people, or (3) pursue some kind of tourist or missionary purposes (it's fun to come to exotic places and to work with different people). In their work on the project in northern Arizona among American Indian communities, the NAPPASA prevention researchers came to expect that they would need to justify and rejustify themselves on these issues in both public and small group meetings.

One of the methods that the academic researchers used to ensure that a long-term agenda was developed and followed was the institutionalization of an active NAPPASA Advisory Board whose members were nearly all American Indians and local residents. These advisors were very helpful in focusing the project agenda on making long-term investments, on the importance of local values, and on the necessity of obtaining local input at each successive stage of the project. The advisors were also able to require that the principal investigator rejustify his motivations and goals during Advisory Board meetings so that these questions and his answers could be safely observed by the project's American Indian staff.

Obtaining Local Input by Listening to What They Have to Say

Being a good listener is valued by many cultures and by most persons in functional partnership endeavors. However, it is rarely clear how being a good listener will be defined by different speakers, especially when there are cultural differences between the speaker and the listener. Sometimes, it is simply the very *act of listening* that is the main point. *Proving that you have been, are now, and will be listening may be the message that community gatekeepers want to get from the prevention researchers.* This was true on the NAPPASA project even when it became apparent after a good amount of listening that there was great commonality in personal values and commitment to the prevention program between the outsider research team and their com-

munity partners. As has been discussed in the "Why us, Why you?" issues, the act of listening to how American Indian values could shape the programs served to *validate* the legitimacy of the community's active role in shaping the prevention partnership.

Some of the NAPPASA project's more effective demonstrations of "listening to what they have to say" arose from two qualitative methods of formative research: (1) *focus groups*, and (2) *key informant interviews* with different subgroups within the host communities. Focus groups had been planned as an important part of NAPPASA's pilot year research protocol in order to elicit three kinds of information: (1) any existing styles of discourse about HIV / AID and AOD, (2) channels of communication on HIV / AIDS, AOD abuse, and (3) local preferences for including these topics in prototype school- and community-based preventive intervention programs.⁵ In all, the project successfully conducted 14 focus groups early in the first year. The group size was small (six to eight persons), they were separated by gender for the youth groups, and they were conducted by carefully trained, context-appropriate group facilitators. A short list of questions was asked in a non-threatening sequence. The focus groups provided very useful information about: (1) baseline knowledge and communications and possibilities for intervention prototypes (Trotter, et al., 1993a) and (2) health beliefs including risks for HIV / AIDS and AOD abuse and their preventability through risk avoidant behaviors (Trotter, et al., 1993b; Quintero, et al., 1992). The lesson about the use of focus groups in the NAPPASA project seems clear: focus groups are an effective and efficient qualitative research method to use with American Indian youth, especially for exploring culturally sensitive topics.

Listening through focus groups helped to sustain NAPPASA's prevention partnerships in several ways beyond providing the data needed to create culturally sensitive prevention programs. One unanticipated, yet serendipitous, payoff from NAPPASA's use of the focus group method was that the focus groups themselves came to be perceived by the community as important, tangible demonstrations of the project's commitment to truly listening to the local people. Focus groups helped prove that the

outsider academic researchers really wanted to understand local customs and values before intervening to change anything. Taken together with the obvious other activities (e.g., interviews and dialogues with community gatekeepers, staff presentations in English and in Navajo at local community chapter and school meetings), people began to view the research team as "good listeners" and as people who could be trusted to seek local input, to value it, and to keep seeking more of it.

The project leadership is now aware of the importance of the process of listening to the community and the useful roles that ethnographic methods of formative research play in this process. Consequently, focus groups in the NAPPASA project have evolved from an experimental formative research tool to a regularly used method for maintaining ongoing community dialogues and for conducting process evaluations with prevention program participants. *Post-intervention focus groups* have been conducted regularly with teachers and students (separately) to understand and to correct unsatisfactory intervention assessment questionnaire items and intervention curriculum components. Most of these groups are audio-recorded and catalogued and quantified for feedback to the research and community members of NAPPASA's project team.

The project has also begun to videotape focus groups and gatekeeper interviews and to show appropriate excerpts at community meetings. The project staff have been very surprised to discover how focus group videos containing visually recorded statements of personal participation in and contributions to the NAPPASA prevention program are culturally congruent and powerful means to sustain the research partnerships. Audiences of all kinds attend carefully to these videos and seem to find personal connections to these speakers and their messages. The research team also became aware of the importance of sharing what is heard by producing a variety of other kinds of videos well beyond the small number envisioned and described in the original grant proposal. The description of how NAPPASA's video media became an important intervention approach follows a discussion of the next partnership building activity, "Being There."

Showing Respect and Building Mutual Trust by Being There

This theme in NAPPASA's partnership building process has involved a number of overt and covert tests of the research team's adaptability to ways in which local people build working relationships with outsiders. The easiest test of "Being There" involves demonstrating one's willingness to participate in community social and cultural events that are not directly related to the project's research agenda (e.g., sporting events, political rallies, pow-wow's, and—with special invitations—traditional ceremonies). For some traditional Navajo people, the way an outsider shows respectful interest (but not invasive participation) at cultural events is an important sign of his/her adaptability to how things are and should be done locally. Not infrequently, "being there" also means showing a willingness to extend oneself. This may mean taking things slow. This can be a challenge to outsider researchers who come from time and status conscious cultures.

Being confronted with inconveniently delayed schedules and undefinable time frames are very real tests of prevention researchers who want to work in some American Indian communities. These tests can take a number of forms, but the ones encountered most frequently with NAPPASA involved: (1) waiting several hours for scheduled and confirmed appointments at meeting places chosen by gatekeepers, (2) failing to attend a scheduled event or coming unannounced at a later date to a previously missed meeting, or (3) being bumped from a published meeting agenda even when a special trip of hours or days has been made to be present for the agenda item. Whether or not these inconvenient problems in "Being There" were unintentional occurrences or planned tests, they provided useful opportunities to prove something about the NAPPASA project team. Perhaps the most important point to prove on these occasions of inconvenience and lost time was to underscore the project research team's continuing commitment to its community partners—that the project research team is still there, that it will be there in the future, and that the community can trust the team members to do what they say they are going to do.

Strengthening NAPPASA's Partnerships Through Video Media

In writing the grant proposal, the principal investigator asked the reviewers to consider the one or two planned media productions as potentially useful supportive activities for the school-based intervention program. The theoretical bases for choosing the messages and communicators in the videos would be congruent with key elements of Social Learning Theory (Bandura, 1986) and the Diffusion of Innovations Communications Model (Rogers, 1983). Again, focus groups and other ethnographic interview methods were proposed during piloting approaches to identify existing local health beliefs and communications about HIV/AIDS and AOD abuse. This formative research was expected to provide information on culturally sensitive and initially useful prevention messages and spokespersons. In sum, the project would produce media to achieve two research objectives: (1) media targeting the community would prime adult audiences (parents, gatekeepers, and elders) to want to support and participate in AIDS/AOD prevention programs and (2) school prevention curriculum media modules would show local peers modeling and being reinforced for practicing preventive communications skills and choosing attractive low-risk behavioral options. Working toward both of these objectives had greater than anticipated payoff for NAPPASA.

Before beginning any video production, the research team already knew that these media would: (1) demonstrate how the prevention programs would address the values, health beliefs and cultural sensitivities of the participants and (2) connect them to local epidemiology of the HIV/AIDS and the AOD abuse epidemics. The team did not expect that NAPPASA's media instead: (1) would serve as the community's window on the research team's own values, health beliefs and cultural sensitivities and (2) would empower more local persons to become personally involved as spokespersons for prevention.

In retrospect, the project's first video production objective was a fortuitous big step toward extending the community prevention partnerships. The principal investigator had simply wan-

ted a replicable, highly visual introduction to the project which would tell the project's origin story, explain its methods, and show the project's research team and its initial community partners speaking in their own words about the need for a local prevention project and their own roles in it. An interesting prototype video was produced by the project's videographer-anthropologist, but the project's American Indian Community Advisory Board found it unacceptable. Their judgement was, "Too many Anglo (White) faces! . . . Not enough local people." This deficiency was corrected by adding many new visuals, voices, and sounds drawn from local contexts. For example, one new segment showed a very persuasive local Navajo man in recovery from substance abuse describing what he felt like when he learned about his many personal risks for HIV. He expressed fear that he may have infected his family with the AIDS virus. Other new segments showed NAPPASA's focus groups, its curriculum instructors being trained and implementing the pilot curriculum in local classrooms, the project's Navajo community outreach coordinator at a chapter meeting, and community residents being surveyed for their opinions about what was needed for the community prevention program. Finally, a new title—"It's Up to You"—was added to complete the revision of the NAPPASA project introduction video. The re-edited video was then judged by the Advisory Board to be much more relevant to the host communities, because it showed that the project belonged to the local people and was being shaped by them.

During the second grant year, *"It's Up to You"* opened many doors for the project. Nine schools and their many surrounding communities on and bordering the western Navajo Nation and the Hopi Nation joined the project. The video also had powerful messages for Puyallup people in Tacoma, Washington (who brought NAPPASA's programs to their schools), and other audiences across the United States. The success of *"It's Up to You"* encouraged NAPPASA to find resources in order to make many more kinds of project videos. They, too, have proven to be very important in making NAPPASA prevention research programs locally relevant and effective.⁶

Delivering Prevention Program Products to the Community

The NAPPASA project has been committed to giving as much as possible to its community partners. In addition to the prevention programs delivered in the schools and communities, and in addition to the project's prevention network building services in the community, NAPPASA's research team has produced a substantial number of useful products which should endure beyond the life of the research project. These include the over two dozen videos which are distributed locally by NAPPASA and nationally by the Indian Health Service AIDS Program. The DHHS Center for Substance Abuse Prevention has also supported the preparation and national distribution of two NAPPASA videos ("*It's Still Up To You*" and "*Sharing The Prevention Vision*") and the NAPPASA prevention program school curricula (NAPPASA, 1993). These 8th grade and 9th grade preventive intervention curriculum packages will be available at no cost to other American Indian communities by early 1994. The curriculum packages contain Instructor's Manuals, Student Manuals, After-School Activities Guides, and Instructor's Training Guides (NAPPASA, 1993). There are also two versions of student-created NAPPASA photo-novels to serve as booster interventions. NAPPASA has also produced culturally relevant AIDS and AOD abuse prevention posters and flyers. Together, the project's products, staff and community partners are producing what appear to be well-liked preventive intervention materials. NAPPASA's intervention programs have produced interesting findings on their effectiveness in modifying behavioral risks for HIV/AIDS and substance abuse.

Research Findings

NAPPASA is funded as a research project and not as a demonstration of a prevention service. The research team is very aware that knowing how to build prevention partnerships and telling how the prevention research was accomplished are more interesting if the research interventions produce meaningful changes in persons at risk. In the second project year (April 1991 to

March 1992), NAPPASA began the full implementation of the intervention field trials in American Indian schools and communities on and off the local reservations. The project was able to meet or exceed its objectives in the areas of: (1) the participation of students, schools, and communities, (2) the development of culturally sensitive prevention curricula and evaluation measures, (3) the production of supporting media for use in the curricula and community outreach programs, (4) the numbers of American Indian and mixed communities actively supporting or requesting prevention research partnerships with our project, and (5) the dissemination of prevention program materials and research findings. Accomplishments in several of these program areas for the project's second year—the first field trial year—are summarized briefly below. Additional results are reported elsewhere (Baldwin, et al., 1993; Rolf, et al., 1993).

School Partnerships. After the pilot year findings were available, the research team proposed increasing the number of schools receiving intervention from the three planned schools to insure obtaining adequate numbers of subjects within grades and to decrease potential subject attrition due to school transfers. In fact, active partnerships were achieved with *nine* schools in Arizona in the second year (not counting the two Chief Leshi schools in Tacoma, Washington). Three of the nine Arizona school partners are high schools and six are junior high schools. Excluding the Flagstaff school system, the collaborating schools represent the major schools serving youth from the southwestern Navajo Reservation and the Hopi Reservation.

Subject Recruitment and Retention. During the second and third project years, over 2,000 adolescents from rural Reservation and border town communities participated in the NAPPASA prevention curricula. In taking the program, they have provided high-quality, longitudinal, non-anonymous data about their thoughts, behaviors, and intentions on a broad range of prevention topics. During the 1991–92 school year, 872 eighth and ninth graders participated in intervention or non-intervention conditions. About half were eighth graders and half ninth graders. Recruitment and retention were excellent, with 95% of the total grade samples participating at baseline and one month

posttest and 88% reassessed at three to six month follow-up assessments. (During the 1991-92 field trial, intervention was also provided to 100 urban junior and senior high school students at a BIA school in Tacoma, Washington, where the NAPPASA program was invited in to help cope with the urgent prevention programming needs which arose with the discovery of an HIV-infected high school student.)

Outcome Findings. Only the initial findings from pretest to posttest comparisons are presented here, and they are very encouraging. Longer term results are reported elsewhere (Rolf, 1992; Rolf, et al., 1992; Baldwin, et al., 1992; Rolf, et al., 1993). Analyses on a sample of 460 *ninth graders* (86% American Indian, 55% female, mean age = 14.6) from two reservation high schools and one border town high school indicate that the five-week NAPPASA Stage 1 school-based interventions produced positive changes in targeted AIDS and AOD abuse prevention areas. Process Evaluations revealed NAPPASA's school-based curriculum also produced high approval ratings from the participants, the students, the teachers/instructors, and the schools' administrations. The self-report questionnaires used at baseline and at the post-intervention five weeks later (95% retested) indicated statistically significant positive changes ($p < .01$, 2-tailed) from pre-test to post-intervention. In sum, the outcome evaluations revealed that the *NAPPASA intervention curricula increased*:

- AIDS and AOD abuse knowledge
- self-efficacy for specific prevention skills
- ease of communication about STDs, AIDS, sex, AOD abuse
- perceptions of harm from drinking
- belief in alcohol's increasing one's risks for AIDS
- belief in ability to help protect friends and family from AIDS
- personal concern about AIDS threats
- belief in the importance of values (personal, family, and cultural) in helping one avoid risky behavior.

In addition, the outcome evaluations also revealed that the *NAPPASA intervention curricula decreased*:

- misconceptions about vulnerability to HIV infection
- reported availability of AOD when teens got together socially

- self-image as someone with a heavier drinking style
- cigarette use
- thinking about the good and bad outcomes of sex
- belief that it is improper to talk about sex, STDs, and AIDS.

Other analyses (reported elsewhere) show that the post-intervention gains were sustained for three to six months, as indicated by follow-up evaluations. Additional analyses also examined subgroup differences in outcomes as a function of baseline levels of drinking, sexual activity, and beliefs.

Concluding Comments

There is always so much more to learn from working in prevention research partnerships with communities, and especially when the partnerships cross cultural boundaries between the community groups and the research teams. Both groups can quickly find some common ground when they communicate their feelings and values concerning the new prevention services to be provided in the research program. Each group can gain further respect from the other when they find ways to actually demonstrate how specific services can be created locally to help improve the quality of life and the health of the community. The community partners themselves need to recognize that they can gain the trust of the researchers by explaining clearly how inclusion of local customs can increase the acceptance and the effectiveness of the new prevention program. The prevention researchers also have an obligation to foster cross-cultural understanding by describing to their community partners the culture and values that are part of academic, theory-based research. It should be made very clear to the community that there is little credit from academia for donating the researchers' time to building community prevention research partnerships, working to promote an at-risk community's empowerment in prevention programming, or for developing functional, culturally sensitive prevention programs unless these activities lead to scientifically sound, publishable data. When such cross-cultural communication is achieved, the prevention partnership will produce useful products and growth experiences for both the research team and

community participants. On the community side, the experience of creating and evaluating the new prevention programs should give them a sense of empowerment and accomplishment. On the other side, if the partnership creates a prevention program that produces scientifically sound evaluation data, it gives the prevention researchers a gift of an improved quality of life in academia. The NAPPASA project is giving such gifts to its partners.

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End Notes

1. The author's prevention research experience spans twenty years during which he has served in various research roles ranging from an academic institution-based principal investigator and co-investigator on research grants to a visiting scientist staff person in National Institute of Mental Health's Prevention Research Program. The author has helped design and implement field preventive intervention projects in the nascent day care system of Vermont during the 1970s in schools in rural Harford County, Maryland, in inner-city Baltimore neighborhoods, on the streets and favelas of Belo Horizonte, Brazil, during the 1980s and during the early 1990s in some American Indian communities and schools in northern Arizona and Tacoma, Washington. Each of these different settings required hard work toward achieving some common prevention research objectives: (1) gaining admission to the community, building trust, (2) performing the promised prevention intervention in scientifically and culturally acceptable ways, and (3) disseminating scientific reports and locally usable prevention program products. In the author's experience, there have been some commonalities in how these research objectives have been reached across these community settings. However, there have also been considerable differences in the type of approaches and the extent of the research projects' resources devoted to achieving these research objectives. This variation results from differences in each host community's local history with outsiders, culture, institutional structures, and favored socio-political processes for developing prevention programs for behavioral health problems.
2. More detailed information on the NAPPASA project's program development activities, its preventive intervention program products, and the findings of the field trials can be

obtained from the author. Manuscripts are from Baldwin, J., et al., 1993; Rolf, J., 1992; Rolf, J., et al., 1993.

3. The position of On-Site Project Director is capably filled by Dr. Julie Baldwin, who shifted her permanent home from Baltimore to Flagstaff, Arizona, at the start of the project. She holds a Ph.D. in Behavioral Sciences from the Johns Hopkins School of Public Health, and she has great expertise in the development and evaluation of school-based prevention programs.
4. The Coordinator of Community Programs for the NAPPASA Project is Rose Denetsosie. She has served the project and the local people extremely well by building effective channels of communication between the project and the community so that all could share their prevention visions with creativity, integrity, and courage.
5. Actually running the focus groups was vital to creating the needed support from the community. They helped overcome some existing cultural stereotypes and program barriers that are typically found in the formative stages of research into AIDS prevention. Sometimes the barriers to be overcome are also found in the scientific community. With the NAPPASA project, it turned out that simply proposing to conduct focus groups, in the absence of published reports on American Indian focus groups, almost jeopardized the funding of the project. An anthropologist scientific peer reviewer of the NAPPASA grant proposal had predicted that the proposed focus group discussions about sex and sexual transmission of HIV/AIDS probably would not work with Navajos because the topics were culturally too sensitive and perhaps even "Taboo." Further, this peer reviewer reasoned that if there were real cultural barriers to focus group discussions, then there might be fatal scientific flaws in the grant proposal's theory-based preventive intervention (i.e., focus groups would be the wrong qualitative research method, *and* the proposed peer group-based skill-building interventions to strengthen preventive communications and risk reduction attitudes about unsafe sexual behaviors probably would not work either). Fortunately, the majority of the NIAAA Initial

Review Group (IRG) committee saw the plans to use group-based formative research techniques and social cognitive theory-based interventions as a common-sense, best-bet approach to discovering and developing an effective culturally relevant prevention program. The research team's success with focus groups also led to an invitation to conduct some groups with American Indian youth in Los Angeles for a DHHS study on HIV prevention for hard-to-reach youth (Karimi, et al., 1991).

6. There are now several types of videos: (1) *Introduction to NAPPASA* —introduces new schools to the project's purpose, methods and staff, as well as to the project's commitment to a spirit of continual sharing between the givers and the receivers of the project's programs; (2) *Prevention for Two Epidemics* —introduces local communities to the linkage between the HIV/AIDS and AOD abuse epidemics; (3) *Local Spokespersons & Role Models*—shows local spokespersons and role models delivering educational/motivational messages about prevention in their own words to the community in recognizable settings; (4) *Curriculum Segments*—integrates into half of the 48 NAPPASA intervention curriculum class sessions information on identifying targeted problems, suggesting positive options, and modeling preventive behavior by peers.

Part IV

Alcohol Prevention Research in Ethnic/Racial Communities: Case Studies

Introduction

Part IV of this monograph examines the four major ethnic/racial communities included in the working group: American Indians and Alaska Natives, Hispanics, African Americans and Black Americans, and Asian Americans and Pacific Islanders.

Each section of Part IV corresponds to the four major ethnic/racial communities. Each section contains three papers. First, a paper is written by an academically based researcher and focuses on current research findings and state-of-the-art research. Second, a paper is written by a community-based researcher and focuses on specific community studies. Finally, the third paper in each section is a *discussion* paper and is written by a community advocate, clinician, or representative from each ethnic/racial group. The papers show diversity in focus, format, and depth of presentation. With one exception (May), all papers in Part IV are written by members of the corresponding ethnic group.

The diversity in focus reflects one major objective of the working group: to foster a dialogue among the various groups of professional researchers, community strategists, advocates, clinicians, and representatives who are working to prevent alcohol-related problems in ethnic/racial communities. Collaboration can be developed and new alliances built between academic researchers and ethnic/racial communities from this dialogue.

Affirmation of this need for dialogue arose as the working group was organized and speakers were selected for each ethnic/racial group. On the one hand, some community members argued that research findings that emanate from the academy are not useful to the community where people live and die of alcohol-related problems. This is so, they continue, because the scientific findings in no way reflect what is actually happening in the community. On the other hand, some academic researchers argue that they do not have *access* to ethnic communities to conduct scientific community studies. Some community representatives stated that academic researchers raid and pillage communities to obtain what academic researchers need to further their research careers. Finally, some community members were concerned because academic researchers have not approached their communities for purposes of doing research.

The structure of the working group provided all groups the opportunity to identify the most effective ways to conduct prevention research to benefit both the ethnic/racial groups and research communities. The hope was that a dialogue between academic researchers and ethnic/racial communities would increase future collaboration between them, develop greater sensitivity among researchers to the specific prevention needs of ethnic communities, and develop relationships of trust between researchers and community members so that relevant research could be designed and useful prevention strategies could be implemented.

Academic researchers and community members need to understand and analyze the social processes that take place in their *interaction*. It is in this interaction where the hazards lie. The prevention of alcohol-related problems can be found in this interaction. The working group discussions and the papers in this section reflect the efforts of all groups to improve the quality of alcohol prevention research in ethnic/racial communities. Quality research is needed for quality service provision in these communities.

The Prevention of Alcohol and Other Drug Abuse Among American Indians: A Review and Analysis of the Literature

Philip A. May

Introduction

The 1990 Census counted 1,959,873 American Indians and Alaska Natives in the United States, which is 0.8% of the entire population (U.S. Bureau of Census, 1991). There are currently over 300 federally recognized tribes, and the social and cultural variation among them is great. Although an increasing proportion of Indians and Alaska Natives are now living and working off-reservation, Indian populations tend to cluster in the Western states both on and next to reservations, and in municipalities that are near reservations. Sixty-six percent of all Indians live in ten states, eight of which are in the West or Midwest (Hodgkinson, Outtz, and Obarakpor, 1990; Snipp, 1989).

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The Indian population is young because of a birth rate that has been consistently twice that of the United States average. In 1987 the crude birth rate for Indians and Alaska Natives was 28.0 per 1,000 population compared to 15.7 for the general United States population. The median age of the Indian population was 22.6 in 1980 as compared to 30 years for the United States (Indian Health Service, 1991a). Some traditional tribes, such as the Navajo, had a median age as low as 18.8 in 1985 (Baris and Pineault, 1990). Average socio-economic indicators for many tribes are quite poor (Hodgkinson, et al., 1990; Snipp, 1989), but within these aggregated data there is a wide range of individual situations, from very poor, to a growing middle class, to some Indians who are quite well-to-do. Contemporary patterns of behavior vary widely from one Indian community to the next, based on a variety of factors including: the traditional folk culture of the tribal group and the relative rate of modernization and change that has occurred in recent decades (May, 1982).

By definition, prevention of alcohol and other drug abuse among Indians is very promising. Because so many American Indians are young, prevention efforts might prove to be particularly successful in heading off bad habits, risky behavior, and addiction before they form or become entrenched. Furthermore, the fact that many Indians live in relatively concentrated areas (e.g., reservations or urban neighborhoods) may also be an advantage. Tribal identity and close kinship ties may also be tapped for prevention advantage.

There are also many impediments to prevention as well. Some of these impediments have their roots in: the devastating history of Indian and U.S. Government relations over the past four centuries, the poor socio-economic status of many Indian families, and the lack of job and life opportunities that exists on many reservations and in the rural areas of the Western United States. Each of these factors creates barriers to prevention which challenge health and public health initiatives.

From a research and evaluation perspective, the prevention of alcohol-related and alcohol-specific problems in American Indian communities has received neither adequate nor sufficient attention. Of the prevention efforts that have been undertaken

among Indians, few have been evaluated (Office for Substance Abuse Prevention (OSAP), 1990). When prevention evaluation has been done among Indians, process evaluation is most common, and measures of outcome are rare. Furthermore, much of this evaluation research is not pursued with adequate vigor or rigor, and little has reached print in any medium, particularly scientific journals. Finally, very little prevention research carried out among Indians has been prospective in nature. This does not mean that prevention performed by various tribes, the Indian Health Service (IHS), the Bureau of Indian Affairs (BIA), State agencies, or others are not effective. It has not really been researched or evaluated adequately, and therefore one has limited means of knowing whether it is effective.

History of Alcohol Treatment and Prevention Among American Indians

The prevention of alcohol and other drug abuse had received very little attention in Indian communities until the decade of the 1980s. Before that time, treatment was the most frequently discussed issue in alcohol circles. Many other public health problems were the major foci of attention. The general paradigm of the pre-1980s was treatment and prevention of infectious diseases. Epidemics of infant diarrhea, tuberculosis, hepatitis, otitis media, and influenza took precedence over other health issues, and their solutions tended to be centered around hospital and clinic settings (Broudy and May, 1983). Prevention, particularly of behavior-related health problems, was not a high priority before the 1980s. The record of the Indian Health Service in lowering the rates of infectious diseases has, however, been outstanding (IHS, 1991a; Rhoades, 1987; Office of Technology Assessment (OTA), 1986). This has made a paradigm shift possible in recent years toward a greater emphasis on health promotion and disease prevention.

The Office of Economic Opportunity (OEO) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) were the first Federal agencies to fund alcohol treatment programs for American Indians. These began in the late 1960s and early 1970s.

The Indian Health Service, however, did not have an office of alcoholism until 1976, when the "mature" NIAAA programs (those that had received five years of Federal funding) began a gradual transfer to the administrative control of IHS (IHS, 1986). The major focus of Indian alcoholism programs for many years was providing minimal treatment services to chronic alcoholics in most of the federally recognized reservations and tribal communities. Offering minimal treatment services is still the norm. Even those reservations with great need have inadequate resources for the problem at hand (Raymond and Raymond, 1984; Mail, 1985; Silk-Walker, et al., 1988).

Within Indian country today, and for at least the past seven years, health promotion and disease prevention are very much advocated. In a number of health promotion topics such as exercise for diabetes prevention and control, smoking cessation, injury control, and others, prevention is advocated and being programmed (see May, 1988a for a review of some of these programs for youth). Alcohol and other drug abuse prevention, however, appears a little slower to commence and gain momentum, except in a few special sub-topics (e.g., Fetal Alcohol Syndrome) and among some particular sub-populations (e.g., schools). This, however, is not unusual for many groups and/or communities in the United States. Ambivalence about alcohol is everywhere, and highly politicized discussions about treatment and prevention paradigms and policies consistently cloud the vision of, and planning for, the future (see Beauchamp, 1980).

In this paper, an eclectic, objective public health approach will be taken. The major criterion for judgment is whether a prevention program, policy, or idea *will reduce the toll* taken by alcohol abuse (whether chronic, acute, or sporadic). There are many types of alcohol abuse and many paths to alcohol problems and addiction (Institute of Medicine, 1990). Shakespeare wrote in "Twelfth Night" (IIv.):

"Some are born great,
 Some achieve greatness,
 and some have greatness thrust upon 'em."
 (documentation in Evans, 1968)

The same can be said of many behaviors other than greatness, including alcohol abuse and addiction. Some people are born drunk (Fetal Alcohol Syndrome), some individuals and peer groups achieve alcohol abusive problems and addiction through purposive action, and others seem to fall victim to life's circumstances and more passively develop alcohol-abusive patterns and addictions.

Another way of stating this point is that alcohol problems are "heterogeneous." The Institute of Medicine (IOM) volume entitled *Broadening the Base of Treatment for Alcohol Problems* (1990) has pointed out that alcohol problems are heterogeneous: in etiology, in the course that the affected individuals and problems take, and in their presentation of consequences and needs for treatment and prevention. Therefore, the IOM advocated a terminological map and a broadly focused paradigm which covers drinking patterns from light to moderate to substantial and heavy. Furthermore, they indicate that these various drinking levels and styles are associated with particular types of problems from abuse and dependence which range in severity from mild to moderate to substantial to very severe (Institute of Medicine, 1990, pp. 31-36). This document makes a strong case for the need to coordinate multi-faceted prevention programs with a variety of treatment programs.

Therefore, programs of both prevention and intervention must be multiple and/or multifaceted to deal with the different paths to alcohol problems and the manifestations thereof. Furthermore, a variety of approaches are necessary to deal with the many controllable or manipulable aspects of the problem as presented by the various hosts, agents, and environments of alcohol abuse. Different types of abuse are associated with various manifestations of the problem and require different programs of prevention.

Four Common Drinking Styles

Some studies have described a variety of drinking styles among most American Indian groups (Weisner, et al., 1984; Levy and Kunitz, 1974). Most frequently mentioned are four: abstinence, recreational, anxiety, and moderated social drinkers (Ferguson,

1968; May, 1982, 1989a). Of these four styles only two are, by definition, linked to problems: the recreational and the anxiety. Abstinence, very common among many tribes (see May, 1989a), particularly among the middle-aged and older, obviously causes no alcohol-related problems. Similarly, many acculturated Indians tend to drink as do others in the occupations, organizations, or strata of society to which they are attached (see Levy and Kunitz, 1974; Liban and Smart, 1982). Many Indians, therefore, tend to practice a moderated or light social drinking style that produces few or no problems related to morbidity, mortality, arrest, or other health or social problems.

Ferguson (1968) described the recreational and anxiety drinkers among the Navajo, and these types are very common among most Indians and Alaska Native groups. The **recreational** drinker is typically a young male who drinks with friends (predominantly male, but mixed as well) for weekends, parties, special occasions, and other social events. As with other groups of young persons, drinking and intoxication are important for social cohesion and are generally highly valued. Recreational drinking among Indian groups of many tribes may only be different from other groups in the United States in matters of degree and cultural meaning. As described by many authors, Indian recreational drinking is more rapid, more forced, and the "bouts" are extended over long nights, entire weekends, and for other lengthy periods (Hughes and Dodder, 1984; Lurie, 1971; Dozier, 1966; Savard, 1968; and Weisner, et al., 1984). Very high blood alcohol concentrations are commonly found in Indians who practice this style of drinking.

The recreational drinker is more fitting of the term alcohol abuser, while the **anxiety** drinker is more akin to an alcoholic. Anxiety drinkers are older, drink chronically, are more solitary, and are generally physically addicted to alcohol. They generally drink cheap wine and beer and supplement with hard liquor, but will consume most any alcoholic beverage available. They also turn to non-beverage items that contain alcohol (e.g., hair spray, after shave, Lysol) when necessary or even for a special "kick." Anxiety drinkers are mostly unemployed, live in border towns and skid row areas, and are not usually associated with

the mainstream society of their tribe or of Western society. Most anxiety drinkers are ostracized to a great degree, whereas the recreational drinkers may be in mainstream society and only associated with abusive peer clusters when drinking.

The above two patterns represent at least two types of alcohol abusive or alcohol problem-generating styles that must be addressed by prevention and treatment programs in most tribes. If a prevention/treatment program is only addressing one type, it is an incomplete program. Furthermore, there is age variation associated with all drinking styles, and there may be other problem drinking patterns in communities that exist in addition to, or in place of, these types. The point is that different drinking styles dictate different prevention/intervention needs and approaches (see May, 1986).

Introduction to the Prevention Literature

As documented below, the literature on prevention among American Indians is not extensive, but it is larger than many might suspect. Many professionals and lay people alike frequently seem to assume that the published literature on Indian health issues is in general small. Furthermore, prevention efforts were, until recently, believed by many to be rare among Indians. Review articles on prevention of drug abuse among Indians have generally concluded that alcohol and other drug-related problems affect a significant number of American Indians, that a great deal needs to be done in prevention among American Indians, that the extremely young median age of Indian populations is an advantage for prevention, and that treatment and rehabilitation would not alone be sufficient, even with services of the highest caliber (see Westermeyer and Peake, 1983; Mail, 1985; Beauvais and LaBoueff, 1985; May, 1986, 1988b; Silk-Walker et al., 1988; OSAP, 1990). Furthermore, several reviews have called for a greater emphasis on drug abuse prevention. This area, then, is awaiting further development and documentation of its effectiveness.

Major Prevention-Review Documents on Indians

In the past decade and one half, several prevention theory/advocacy and literature review papers and monographs particular to American Indians have been published. Some cover drug abuse exclusively while others are predominantly from a mental health perspective.

An early document advocating a prevention approach to alcohol problems was a report from the 1977 Indian Health Service (IHS) Task Force on Alcoholism that was convened in 1969 and 1970. The report, titled *Alcoholism: A High Priority Problem*, started with a disease definition and emphasized treatment; but, the report also addressed alcohol-related problems as behaviors amenable to broader activity in the community and society. Besides the standard medical services, social services, and psychiatric care, this document called for health education for prevention, planning, and an emphasis on new community relationships related to alcohol programs and problems. Planning was emphasized on an interagency and a community-wide basis to support and complement medical and psychiatric care (IHS, 1977).

In a monograph that was produced and distributed from the Colorado State University Psychology Department, Beauvais (1980) reviewed the extant literature on alcohol and drug use among Indian youths and made explicit suggestions for Indian community prevention and health education programs. This monograph is unique among the prevention review documents covered in this section in that it has a stronger emphasis on drugs other than alcohol. Based on the literature, Beauvais (1980) presents several "ways to help" for prevention. These include: parent, student and school staff education, hospital-based interventions, the use of role models, and the application of traditional cultural and craft activities for prevention. Finally, the monograph contains detailed and valuable generic information about the effect of a variety of drugs on the human body and human functioning.

In another ground-breaking monograph, one that is primarily concerned with mental health issues, prevention is the sole topic.

Edited by Manson (1982), the monograph, *New Directions in Prevention Among American Indians and Alaska Native Communities*, contains 15 articles dealing with a variety of issues related to Indian mental health. Specific topics include general prevention research theory and practices applied to American Indian communities, primary prevention, evaluation of prevention efforts, training for prevention efforts, and the role of cultural networks in prevention. All of this is in addition to a variety of mental health topics, including alcohol abuse. Forty-six articles on prevention of alcohol and drug abuse problems (mostly primary prevention) are identified in the introductory chapter by Manson, Tatum, and Dinges (1982). The fact that mental health and drug abuse issues are intimately related is underscored by this monograph. Further, the monograph represents an excellent resource for reviewing the issues, theory, and techniques of prevention among American Indians and Alaska Natives. Concepts and approaches in this work might be brought to bear on alcohol-specific problems. But the reader should bear in mind that the prevention of alcohol and other drug abuse requires somewhat different approaches than does the prevention of certain psychiatric problems. This will be evident in a later section of this paper.

Trimble (1984) concentrated on alcohol and drug abuse prevention research both by reviewing the literature and concepts and by making recommendations for needed direction in future prevention research. His work draws from 89 literature sources and makes ten recommendations for future primary prevention research projects, six recommendations for secondary prevention, and inquiry about research at the tertiary level (prevention of further medical, social, and psychological problems once an alcohol problem is manifest). Tertiary level research was found by Trimble to be virtually non-existent.

In 1985 Beauvais and LaBoueff published a paper that reviewed the theoretical issues related to drug and alcohol abuse prevention among Indians. This paper provided theory and data upon which to base such programs, reviewed approaches to prevention that begin from within the community, and provided guidelines for community action in prevention. Emphasis in this paper is placed on community activity that should be undertaken

on a step-by-step basis in prevention. The authors explicitly state that prevention activity should not use "top down" approaches initiated from the outside.

In a previous review of prevention programs for Indians, May (1986) addressed both treatment and prevention literature from an evaluative perspective. Treatment programs in Indian country that had been evaluated before 1984 were found to have no greater success than other treatment programs elsewhere. The range in success rates, using various definitions, was from 19% to 40%, which left room for improvement (May, 1986). Furthermore, there were (and still are) many drug and alcohol abuse problems that were not addressed by most Indian-oriented treatment and prevention programs (May, 1986; Weibel-Orlando, 1984, 1989; Weisner, Weibel-Orlando, and Lang, 1984). Many areas of alcohol-related morbidity and mortality (motor vehicle crashes, trauma, suicide, and homicide), women's drinking issues, drinking among the dropout and out-of-school population, and fetal alcohol exposure were salient examples of under-addressed issues cited in this article. The modal alcoholism programs for Indians were found to target middle-aged, adult males with chronic drinking problems (anxiety drinkers). As in the early 1980s, treatment is still emphasized in most programs, leaving little emphasis, time, or resources for prevention.

A final review document is a monograph written by Candice Flemming and others and published by the Office for Substance Abuse Prevention (OSAP, 1990). This monograph reviews 80 articles identifying 60 preventive interventions carried out among Indians. It further addresses cultural, historical, community, and research issues important to Indians. In addition to the literature review, this monograph contains brief descriptions of 52 different programs or approaches described in the literature. It also contains a section that provides an analysis of 16 Indian and Alaska Native programs funded by OSAP in 1990. Finally, the monograph summarizes data from a telephone survey with prevention project managers of Indian programs. This monograph is a complete and valuable review of the prevention literature on drug abuse (and a number of combined drug abuse/mental health programs). It is a snapshot of the state of the

art in several existing prevention programs among American Indians and Alaska Natives.

The OSAP (1990) monograph concludes with seven recommendations. These recommendations are: (1) more needs to be known about how prevention programs survive for the long term, (2) the relationship between traditional culture and drug use needs to be studied further, (3) every project should be "rigorously" evaluated, (4) more should be learned about the role of peer clusters in drug abuse, (5) general community development can make prevention efforts more effective, (6) more comprehensive approaches are increasing and should be encouraged, yet broader economic and environmental risk factors are rarely addressed, and (7) more focus must be given to community norms concerning drug abuse and how change is accomplished and sustained. The monograph also reports that most prevention programs are school-based (OSAP, 1990, p. 39, Table 6) and that evaluation of most programs was lacking. Only 56% of the programs surveyed had research designs with both process and outcome evaluation.

The above themes presented in the review papers and monographs should serve as orientation and background for the reader of this paper. They very succinctly capture some of the ascendant and current issues in prevention of alcohol and other drug abuse among Indians today.

Prevention Literature: A Catalogue of Recently Published Sources

Prior to 1980, much of the literature which existed on American Indian alcohol and mental health issues were either unpublished or published in obscure places such as committee reports, center documents, or conference proceedings (Mail and McDonald, 1980). In some of these works prevention programs were mentioned, and in several cases presented in a detailed fashion. But overall, prevention ideas were neither widely distributed, nor did they receive adequate attention. In the major bibliography on alcohol use and abuse among American Indians by Mail and McDonald (1980), there are 25 citations in the index under

prevention of alcohol problems, eleven for prevention of suicide, and two for prevention of delinquency (p. 344). Of the alcohol prevention citations, 52% are papers that were unpublished and a major focus on prevention was not really evident in 42% of those papers. These works instead focused on issues (e.g., treatment or service delivery) or topics (e.g., suicide, self-esteem, and mental health) other than primarily on the prevention of alcohol abuse problems.

In preparing to write this paper, a literature search was initiated through MEDLINE on the topic of "prevention of alcoholism/substance abuse among Native Americans." The search was from 1982–1992, and 26 articles were identified. This search formed the basis of the review and discussion in this paper, along with the literature identified in the previously mentioned works by Manson (1982), Trimble (1984), OSAP (1990), and others. As a "key word" in the literature, then, prevention is not manifest to any great degree in the area of alcohol abuse among American Indians.

Presented below in figures 9-1 through 9-3 are listings of articles and other prevention-oriented works that should be useful to those researching and pursuing applied programs in prevention. An attempt has been made to focus as completely as possible on alcohol and other drug abuse programs that are primarily or substantially prevention oriented. There was a conscious attempt to exclude programs that are primarily oriented to mental health and psychiatric problems or those that exclusively focused on alcoholism *treatment*. The emphasis in these figures is on the three levels of prevention from tertiary to primary.¹ Because some programs have diverse elements that span all three levels, categorization was difficult.

Tertiary Level Prevention

In figure 9-1 the programs that emphasize tertiary strategies with Indian alcohol abuse are covered. As Trimble (1984) indicated, it is difficult to find tertiary programs described in the alcohol literature on Indians. One could include many more alcoholism treatment programs here, but that is not the intent. This paper is written to highlight those with the greatest emphasis on tertiary

Figure 9-1. Tertiary Level Prevention of Alcohol and Substance Abuse Problems Among American Indians

<i>Author, Date</i>	<i>Topic; Target Groups</i>
Shore and Von Fumetti, 1972.	Three adult alcohol treatment programs; Northwest Indians.
Wilson and Shore, 1975.	One adult alcohol treatment program; Northwest Indians.
Weibel-Orlando, 1989.	Description of 26 adult alcohol treatment programs; Far West.
Ferguson, 1968; 1970; 1976; Savard, 1968.	Etiology and description of treatment and intervention (including antabuse) with chronic adult alcoholics; Navajo.
Price, 1975; Hagan, 1976.	These two articles advocate new policy in the criminal justice system which decriminalizes alcohol intoxication and seeks therapeutic alternatives; Canadian Indians.
Westermeyer and Peake, 1983.	Etiology and evaluative follow-up of adult alcoholics; Chippewa.
Albaugh and Anderson, 1974; Pascarosa and Futterman, 1976; Blum, Futterman, & Pascarosa, 1977.	The use of Native American church rituals and the sacramental use of Peyote to treat alcoholism among adults; Plains tribes.
Masis and May, 1991.	Fetal Alcohol Syndrome prevention by focusing on chronically alcoholic women at high risk for causing FAS; Navajo.

prevention, efforts that minimize the adverse consequences of severe alcohol abuse once it is manifest. The above articles represent this thrust in several ways. The first three listings, Shore and Von Fumetti (1972), Wilson and Shore (1975), and Weibel-Orlando (1989) describe the typical methods used in Indian alco-

hol treatment programs and the tertiary prevention issues that are important to consider with adult Indian alcoholics. These articles show a thrust toward managing the effects of alcoholism. Additionally, many other alcohol-related tertiary prevention issues are linked to other areas of health such as injury, disability, and protection of the alcohol abuser's family, but these are beyond the scope of this paper.

Not exclusive of the scope of this paper, however, are the articles by Ferguson (1968, 1970, 1976) and Savard (1968) which very completely describe the use of antabuse, arrest diversion, milieu change, and other tertiary methods of prevention and intervention with chronic alcoholics. Price (1975) and Hagan (1976) have addressed decriminalization, arrest diversion, and arrest-keyed therapy as tertiary solutions to excessive arrest rates for alcohol intoxication among some Indians.

Westermeyer and Peake's (1983) article is unique, for the ten-year follow-up methodology is not only the longest in the Indian alcohol literature, but also is insightful for factors related to chronic alcoholism. The factors studied included (1) longevity, (2) social, occupational, and cultural survival, and (3) drug abuse outcomes and patterns for 45 people who had been treated for chronic alcoholism. Given the high relapse rate for alcoholics, these are vital issues in tertiary prevention.

Also included in the literature are three articles describing the therapeutic efficacy of providing the values, beliefs, structure, and rituals of the Native American Church to treat and prevent further problems from alcoholism. Albaugh and Anderson (1974), Pascaros and Futterman (1976), and Blum, et al. (1977) all see Native American church practices and peyote as therapeutic agents that can treat problems with alcoholism. The latter two articles, however, seem to emphasize the pharmacology more than Albaugh and Anderson (1974).

The final article in figure 9-1, Masis and May (1991), describes a fetal alcohol syndrome prevention program in Arizona that is highly focused on chronic alcoholic women. The tertiary goals are to prevent future alcohol-damaged children, Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effect (FAE), from mothers who have already had one damaged child or are drinking heavily

while pregnant. This is done by providing counseling, support, birth control, and treatment for alcoholism.

Secondary Level Prevention

In figure 9-2 the more recent secondary prevention resources are listed. As is evident, there are many more secondary prevention programs described in the recent literature ($N=38$) than other types of programs. This has not always been the case, for in the 1960s several of the more influential articles (e.g., Dozier, 1966 and Stewart, 1964) emphasized primary prevention through large-scale social and community-wide influences.

The secondary prevention articles are very useful and provide one with an excellent set of complementary approaches for working with aggregates and/or groups within Indian communities who are high risk by definition (teenagers) or by demonstration of the earliest signs of alcohol use and abuse. The focus in secondary prevention is on these subgroups or aggregates and individuals within them rather than on the entire community, environment, or structural conditions promoting or discouraging drug abuse.

Of all the areas of prevention for American Indians, the secondary level programs provided for youths have been the most common. Although only a few of these programs have been rigorously evaluated, they have been researched and evaluated better than many Indian treatment programs and other levels of prevention. The empirical research that lays the theoretical and scientific groundwork for these programs is very extensively and rigorously researched, especially studies of alcohol and other drug abuse among Indian youth.

The first 15 articles in figure 9-2 are excellent resources for planning prevention, for they are theoretically sound and based on literally tens of thousands of survey responses from individual youths. These surveys have been done all over the United States. The work of Oetting, Beauvais, Edwards, Swaim, and colleagues at Colorado State University has been ongoing for two decades, as has that of Winfree, Griffiths, and colleagues, although on a much more modest scale. All of the overview articles listed in figure 9-2 provide a very sound and tight theoretical base for

Figure 9-2. Secondary Level Prevention Literature on Alcohol and Substance Abuse Among American Indians

<i>Author, Date</i>	<i>Topic; Target Group(s)</i>
<i>(Overview Articles)</i>	
Oetting and Beauvais, 1989; 1991.	Etiology of Alcohol and Substance Abuse applied to prevention techniques; Indian youths.
Beauvais, Oetting, and Edwards; 1985a; 1985b; 1988.	Correlates and trends of substance abuse for intervention/prevention; Indian youths.
Oetting, Swaim, Edwards, and Beauvais, 1989.	Places emotional distress in the proper prevention context; Indian youths.
Swaim, et al., 1993.	Cross-cultural comparisons for insight for prevention programs; Indian youths.
Bach and Bornstein, 1981.	A social learning rationale applied to potential Indian alcohol abuses; Indian youths and adults.
Winfree and Griffiths, 1983a; 1983b; 1985; Winfree et al., 1989; and Sellers and Winfree, 1990.	Social learning theory, differential association theory, and trends of alcohol and substance abuse with prevention applications; Indian youths in the Northwest.
Hoover, McDermott, and Hartsfield, 1990; and Boyle and Offord, 1986.	Alcohol, tobacco, and smokeless tobacco use patterns for designing prevention programs; Canadian Native youths.
<i>(Secondary Prevention Within Alcohol, Mental Health Programs)</i>	
Silk-Walker, Walker, and Kivlahan, 1988.	A survey of a number of the secondary and tertiary prevention issues in an alcohol treatment program; Alcohol abusing adults.
Levy and Kunitz, 1987.	Identifies factors of high risk for suicide and alcohol problems for secondary prevention; Hopi.

Figure 9-2. Secondary Level Prevention Literature on Alcohol and Substance Abuse Among American Indians (continued)

<i>Author, Date</i>	<i>Topic; Target Group(s)</i>
Shore and Kofoed, 1984.	Reviews the premise of five secondary prevention programs for community prevention success; Adults.
Kahn and Stephan, 1981; Kahn and Fua, 1985; Ward, 1984; Fox, Manatonabi, and Ward, 1984.	These four articles describe how alcohol abuse prevention can be undertaken and effective as a community-based mental health/suicide prevention program; Tono O'Odum and Canadian Indian adults.
Parker, et al., 1991.	An Indian-culture based prevention program to build self-esteem and reduce substance abuse; Northeastern Indians.
(School-based Programs)	
Indian Health Service, 1987.	A description and summary of the several hundred school-based alcohol abuse preventive programs of the Indian Health Service; Indian youths and parents.
Manson et al., 1989.	Alcohol consumption correlated with suicide attempts and 22% of all school-based suicide prevention programs have alcohol prevention components; Youths.
Duryea and Matzek, 1990.	Prevention among elementary school children is explained through resisting peer pressure; Pueblo.
Okwumabua, J. O., Okwumabua, T. M., and Duryea, E. J., 1989.	Health decision making was found to be quite efficacious among seventh graders, indicating knowledge of the consequences of their behavior; Pueblo.

Figure 9-2. Secondary Level Prevention Literature on Alcohol and Substance Abuse Among American Indians (continued)

<i>Author, Date</i>	<i>Topic; Target Group(s)</i>
Bernstein and Woodall, 1987.	Perceptions of riskiness increased with a program of health education and life experience; NM Indians, in grades 6-8.
Murphy and DeBlassie, 1984.	Counselor intervention strategies are emphasized; Mescalero Apache elementary school children.
Scott and Meyers, 1988.	Fitness training is found to stabilize alcohol and drug use; Canadian Indian youths ages 12-18.
Schinke, Mancher, et al., 1989; Schinke, Schilling, et al., 1989; Schinke, et al., 1988; Gilchrist, et al., 1987; Schinke, et al., 1985.	American Indian youth are found to benefit from skills training and health education. Results show the youths to have greater knowledge of drug effects, better peer pressure management and lower rates of substance use; Northwest Indian youths.
LaFromboise and Rowe, 1983.	Bi-cultural competence and assertiveness are improved by skills training in a culturally appropriate manner; Indian youths.
Carpenter, Lyons, and Miller, 1985.	A peer managed self-control program successfully taught responsible drinking to teenagers and the results held up for 12 months; Indian teenagers.
Davis, Hunt, and Kitzes, 1989.	A school-based teen center dispensing integrated health services including alcohol education and counseling is described; Pueblo teens.

prevention planning. The bulk of this literature is converging on a common set of variables, theories, and approaches that clearly describe the problem and lay out the most likely approaches for prevention. Most works focus on alcohol and other drug abuse, but a growing body of work is now building on tobacco as well (Hoover, et al., 1990; Boyle and Offord, 1986).

Reviewing the substantive highlights of these works is important here. In the literature, Indian youths generally report that they use alcohol as frequently as or more frequently than other youths in the United States. For example, by the 12th grade, lifetime prevalence of alcohol use is quite high: for Indian males, 96%, and females, 92% (Oetting and Beauvais, 1989). National studies of U.S. adolescents show similar use patterns in that 92% of all high school seniors report having used alcohol at least once (NIAAA, 1990). But the major difference is found in measures dealing with age at first involvement and degree of involvement. According to the major researchers in this area (Beauvais, Oetting, and Edwards, 1985b; Oetting, Beauvais, and Edwards, 1988), the age at first involvement with alcohol is younger for Indian youths, the frequency and amount of drinking are greater, and the negative consequences are more common (see also Hughes and Dodder, 1984; Forslund and Cranston, 1975; Forslund and Myers, 1974). Oetting, Beauvais, and colleagues have found that at all ages and grades a greater percentage of Indian youth are more heavily involved with alcohol than are non-Indians (Oetting and Beauvais, 1989). Several studies indicate that this is both encouraged and expected among many peer groups as the "Indian thing to do" (Winfree and Griffiths, 1983a; Lurie, 1971). Therefore, some drinking at a young age prior to the 12th grade is quite common among Indian youths as it is with other United States youths. By 12th grade, 80 percent of Indian youth are current drinkers, but there is some variation from reservation to reservation (see May, 1982). Severity measures show that Indian youths who drink are more likely to report having been drunk and to have "blacked out" (Oetting and Beauvais, 1989). Just as United States high school data showed an increase in drinking and marijuana use through 1980, and subsequent declines after 1980, the Indian patterns over time

are similar. That is, Indian youths have reported less use of drugs and alcohol in recent years (Oetting and Beauvais, 1989; Winfree and Griffiths, 1985), but a decline in heavy users has not occurred. Heavy use among Indian youth has remained steady at 17 to 20% (Beauvais, 1992a).

Those youths who are most likely to abuse alcohol are those who associate with alcohol and drug abusing "peer clusters." Furthermore, alcohol-abusing Indian youths are those who do not do well in school, who do not strongly identify with Indian culture, and who come from families who also abuse alcohol (Guyette, 1982). Oetting and colleagues (Oetting and Beauvais, 1989) concur, for their findings characterize abusers as having poor school adjustment, weak religious/spiritual foundations, poor family and peer group associations, and little hope for the future. Conversely, Indian youths with strong family attachments, where culture and school are valued and abusive drinking is neither common nor positively valued, tend to be less likely to get seriously involved with alcohol, marijuana, and inhalants, the "big three" drugs common for drug-abusing Indian youths. Low self-esteem, depression, anxiety, and other negative emotional states are not influential in alcohol abuse among Indian youths (Oetting and Beauvais, 1989; Oetting, et al., 1988). Biculturalism (the ability to function well in both tribal, Indian society and the modern, Western world) is a real strength for Indian youths, for it is a trait that is not associated with alcohol abuse or other negative traits that predispose youths to alcohol problems (Oetting and Beauvais, 1991). In their most recent works these same researchers emphasize resocialization (the learning or relearning of modes of adjustment to life that are drug free) in the family, schools, peer groups, and religious institutions as preventive of drug abuse among Indian youths (Swaim, et al., 1993; Beauvais, 1992b).

The second main grouping of articles in Figure 9-2 concerns secondary drug abuse prevention carried out within the context of mental health programs. Many, if not most, of all problems that come to the attention of mental health programs involve co-morbidity with alcohol and other drug consumption (May, 1988b). Therefore, drug abuse prevention has often been devel-

oped in mental health programs. Of the eight articles of this nature highlighted in figure 9-2, six are in a mental health/suicide prevention context, one is within an alcoholism treatment context (Silk-Walker, et al., 1988), and two are in a larger community mental health initiative context (Shore and Kofoed, 1984; Parker, et al., 1991). These articles underscore the many possibilities for initiating prevention of all types from mental health and alcoholism programs, an effort that has been too rare in the past in many Indian communities.²

The final group of articles in figure 9-2 concerns the school-based programs. Most of the prevention programs aimed at American Indians in recent years have been school-based programs that emphasize the previous information about the effects and consequences of drug abuse. Programs such as "Here's Looking at You," "Project Charley," and "Babes" have been used in many Indian communities both on and off reservation (IHS, 1987). Aimed at children from elementary school through high school, these programs are implemented in a variety of ways by staff, faculty, and counselors. Parent involvement is generally not a major component of these programs, and some say the influence seldom goes outside of the school grounds. The effectiveness of these programs has been studied and published very infrequently given the fact that literally thousands of them have been undertaken. The fifteen articles here represent the evaluation of only a few of the programs ongoing in Indian community schools. Furthermore, these programs evaluated and described in the literature are generally of more intensity and of a different modality than the mainstream programs cited above. One should consult the Indian Health Service (1986, 1987) documents for details on the most frequently used school-based prevention efforts.

The consistent themes in the school-based prevention programs are building bicultural competence (LaFromboise and Rowe, 1983), increasing self-esteem and self-efficacy (IHS, 1987), improving resistance and judgment skills, particularly in the face of peer pressure (Duryea and Matzek, 1990; Schinke, Mancher, et al., 1989; Schinke, et al., 1988; Gilchrist, et al., 1987), and increasing the perception of the riskiness of alcohol and drug use (Bern-

stein and Woodall, 1987). Certainly the current etiological literature supports these efforts if taken in the proper context. That is, building self-esteem alone will not solve the drug use and abuse problems. Building new perceptions, values, skills, and support systems along with self-esteem may be the key. Therefore, these programs must also have an effect on the socio-cultural aspects of life and the existence of abusive peer clusters in the life of these youths (Neucomb and Bentler, 1989). This can be accomplished by either direct or indirect influence, but the socio-cultural aspects must be addressed, not just the mental health and psychological issues (Oetting and Beauvais, 1989).

Nevertheless, the articles which document school-based prevention are very useful and can be used as guides and models for others in the future. Furthermore, long-term follow-up of the adolescents who participated in these programs should be pursued aggressively in the coming years, particularly after they leave school and move into adulthood. Eventually, studies of prevention among Indian youth will need to build a strong literature based on long-term outcome evaluation that will pinpoint factors associated with both a lack of drug abuse and overall success in life (Neumann, et al., 1991).

Primary Level Prevention

Moving now to figure 9-3, the primary prevention literature is listed. From overviews of the approach to specific changes in communities to prevent alcohol abuse, this literature is beginning to grow in size and specificity.

Community-based and primary prevention in general has not been pursued to any great degree, for the planning of community action on health problems is also a relatively new approach in many Indian communities (OSAP, 1990). Only in the last 15 years have most reservations been able to begin and to staff programs as basic as their first emergency medical services. Therefore, it is little wonder that the focus on community-wide prevention is new. Other problems were much more pressing in the past. In the 1980s, however, interest in prevention programs was built. This is especially true regarding prevention of behavior-related health programs, such as diabetes (Leonard and Leonard, 1985),

Figure 9-3. Primary Level Prevention of Alcohol and Substance Abuse Problems Among American Indians

<i>Author, date</i>	<i>Topic; Target Area</i>
<i>(Overview)</i>	
Rhoades et al., 1988; Indian Health Service, 1986.	Describes the IHS programs and/or philosophy in the treatment and prevention of alcoholism for over 300 reservations; U.S. Indians.
May, 1986.	A overview of the existing alcohol abuse problems, especially mortality, and a call for comprehensive prevention programs; U.S. Indians.
OSAP, 1990.	A comprehensive review of the literature, prevention programs instituted past and present, and recommendations; U.S. Indians.
Mail, 1985; Mail and Wright, 1989.	Two works on the concepts and necessity of designing comprehensive prevention from the indigenous cultural energies and point of view; U.S. Indians.
Beauvais and LaBoueff, 1985.	Prevention must come from the ground up and the process is described; All Indians.
Marum, 1988.	Community mobilization through workshops and training is described; Alaska Native communities.
Beauvais, 1992b.	A model of substance abuse prevention variables (peer, psychological, social structure, and socialization factors) are presented; Indian youths.
Maynard and Twiss, 1970.	A fully comprehensive study and plan for primary prevention of mental health and substance abuse problems; Oglala Sioux.

Figure 9-3. Primary Level Prevention of Alcohol and Substance Abuse Problems Among American Indians (continued)

<i>Author, Date</i>	<i>Topic; Target Group(s)</i>
(Alcohol-Related Injury Control)	
May, 1989b.	A literature review and overview of alcohol and motor vehicle crashes among Indians with primary, secondary, and tertiary prevention suggestions; All Indians and Alaska Natives.
Smith, 1991; IHS, 1990.	An article and a data monograph which lay out the details of the Indian injury problem, the IHS initiative to implement primary prevention and tools for prevention; All Indians and Alaska Natives.
Macedo, 1988.	A description of community-wide change and prevention of alcohol-related social trauma and injury in two communities and a framework for analysis are presented; Canadian Indians.
(Fetal Alcohol Syndrome)	
May and Hymbaugh, 1989.	Describes a nation-wide primary prevention program directed at Fetal Alcohol Syndrome and using public education through the training of trainers; All Indians and Alaska Natives.
May and Hymbaugh, 1983.	A comprehensive research, clinical assessment, and primary prevention program for a number of tribal communities is described; Southwestern Indians.
Plaisier, 1989.	A primary and secondary prevention program using health education as a vehicle; Indians in Michigan.

Figure 9-3. Primary Level Prevention of Alcohol and Substance Abuse Problems Among American Indians (continued)

<i>Author, Date</i>	<i>Topic; Target Group(s)</i>
(Prevention Based on Policy and Laws)	
May, 1975; 1976; 1977.	Two articles and a doctoral dissertation which examine alcohol legalization/prohibition policies on reservations and the effects of these laws on alcohol-related mortality; Northern Plains tribes.
Back, 1981.	An article which evaluates the effectiveness of prohibition on the Navajo reservation and calls for new policy as a preventive measure; Navajo.
Bellamy, 1984.	A doctoral dissertation which compares the behavioral and attitudinal characteristics of youths growing up on a prohibitionist, a long-term legalization, and a recently legalized reservation; Plains Indians.
May and Smith, 1988.	A survey of opinions about alcohol and alcohol policy with subsequent recommendations for alcohol policy and prevention; Navajo.
May, 1992.	A comprehensive survey of alcohol control policy and primary prevention measures from all over the world applied to Indians and border town communities; All Indians and Alaska Natives.

car seat protection (May, 1988a), and one successful community-wide alcohol prevention program in Alkali Lake, British Columbia ("The Honour of All," a documentary film).

The success of one primary prevention effort on any problem often generates interest in prevention topics of other types. Attention is, therefore, only recently being turned away from treatment, intervention, and other levels of prevention to primary prevention. The focus for solving health problems is leaving the once deadly (but now tamed to a significant degree) infectious diseases and turning toward other morbidity and mortality problems. The epidemiologic transition (Broudy and May, 1983) has made behavior-related health problems more obvious and more important on the list of health priorities. Alcohol abuse and related behavioral health concerns are now issues that can be discussed and eventually addressed in a number of Indian communities (IHS, 1986). The recent OSAP (1990) evaluation of Indian drug abuse programs concludes by calling for more comprehensive, community-based prevention programs that are rigorously evaluated.

The overview articles and monographs in figure 9-3 are excellent at putting forth the rationale and philosophy of primary prevention. The Rhoades, et al. (1988) article and, more particularly, the Indian Health Service (1986) monograph are in many ways a call to commence broader programs of prevention, particularly those that emphasize primary prevention via community change. Getting a large and complicated bureaucracy such as the Indian Health Service moving forcefully in this direction for alcohol abuse prevention, however, will take time. The May (1986) article calls for primary prevention of alcohol abuse, and particularly for a focus on reducing the toll of alcohol-related sequelae (mortality and morbidity) through social policy, environmental change, and broad-based action. The OSAP (1990) monograph's strengths and conclusions were presented in an earlier section, but the concluding emphasis of this work is on primary and comprehensive prevention. Mail (1985) lays out a rationale and several specific considerations for primary prevention initiatives in Indian communities, and the Mail and Wright (1989) piece says that successful prevention programs will have

to come from the communities themselves (see also Beauvais and LaBoueff, 1985). Marum (1988) describes this community generating process with one program in Alaska.

The last overview piece listed, by Maynard and Twiss (1970), was a piece far ahead of its time. From the pilot, model community mental health program at Pine Ridge, South Dakota (1966-the 1970s), a vast amount of research was generated on social and environmental conditions that were related to mental health, drug abuse, and other health and behavioral health conditions. This monograph is a summary of much of those studies. It details the historical, demographic, economic, social, and cultural conditions among the Oglala Lakota (Sioux) at Pine Ridge and analyzes their significance for behavioral health. A large part of the concern are the topics of alcohol and drug abuse. Each section of the monograph concludes with several suggestions for prevention, most of them primary level, as they involve community-wide, structural issues. As a monograph on the primary prevention of mental health and drug abuse problems among Indians, it is extensive and has no peers. It is unfortunately out of print, but might easily be resurrected and reprinted by an appropriate Federal or tribal agency. Too often the behavioral health sciences lack a memory or do not build on previous endeavors.

Four pieces listed in figure 9-3 relate to the prevention or control of alcohol-related injury. The May (1989b) article is a literature review that documents the close tie between alcohol and motor vehicle deaths and injuries and outlines a variety of suggestions for primary prevention. Similarly, the Smith (1991) and IHS (1990) documents outline specific strategies for prevention of all types of injury and present detailed data to guide and support these efforts. Finally, the Macedo (1988) article provides a primary prevention perspective on whole communities that are "injured" and traumatized by modern forces, particularly alcohol abuse, and the paradigm for recovery.

Fetal Alcohol Syndrome (FAS) has been upheld by many as the perfect "spark" or "motivating" topic for primary prevention among Indians (May, 1986). Some would say that Indian communities and some Indian organizations are leading the way in the area of FAS prevention. The three articles on FAS prevention in

figure 9-3 are all examples of using public education, awareness, research, and some diagnostic clinic work to change the primary perceptions and behaviors around this issue. It will be interesting in the coming years to evaluate the long-term effects of prevention programs in some communities that participated in the first FAS prevention efforts.

The final primary prevention area is that of alcohol control policy and laws. Though some scholars have suggested new laws such as legalization of alcohol sales on reservations (Stewart, 1964; Dozier, 1966; Price, 1975), alcohol policy has rarely been used for preventing alcohol-abuse problems. The earlier policy-oriented works in figure 9-3 generally address the issue from a polarized and simplistic legalization vs. prohibition perspective. More recent articles, however, emphasize alcohol policy as a complex web of specific provisions that must be tailored or matched to the tribal community or border towns involved.

All of the above pieces call for primary prevention to be made in a comprehensive, community-generated way. Other communities throughout the world have done so, and some have shown the efficacy of this approach to alcohol issues in a number of settings (Yates and Hebblethwaite, 1983; Beauchamp, 1980, 1990; Institute of Medicine, 1989; Moore and Gerstein, 1981; NIAAA, 1990, Chapter 9; Holder and Stoil, 1988; Pittman and White, 1991). It seems that the non-Indian literature could hold great promise for Indians as well. New community definitions and policy need to find their way further into both research on Indians and application in Indian communities.

While the theoretical worth of community-wide policy and normative change is immense, implementing such change is treacherous and slow. As Gordis (1991) has pointed out, going from science to social policy is an "uncertain road," highly influenced by the types of scientific evidence, cultural and social influences, timing, and many other factors. Similar or even greater pitfalls have been recorded in many Indian and Alaska Native communities (Levy and Kunitz, 1981; Foulks, 1989; Manson, 1989). The nature of the research, the specific research topic, the focus, and the method of scientific approach are all vital and must be matched with the community. Further, the role of the

researcher is very important (Beauvais and Trimble, 1992) and must be one of sensitivity and cooperation.

The Alcohol Abuse Problem That Comprehensive Prevention Must Address

So much has been written on the problem of alcohol and American Indians, both popular and scholarly, that it seems almost absurd to write any more on the scope of the problem. Unfortunately, however, much of what is written on the magnitude, nature, and characteristics of the problem is too general, not critical, and most importantly, not useful for targeted, public health prevention programs. Often the literature that is presented in alcohol epidemiology is too general. Usual presentations indicate that the problem is of great magnitude among Indians, it is out of control, and solutions are elusive. This "Oh, my gosh, ain't it awful" approach is still with us today, and it may lead to a "we gotta do *something*" program. However, more specific targeting is needed for: particular alcohol abuse and alcohol-related problems; specific high risk groups and abusive peer clusters; and particular host, agent, and environmental interventions. This section will briefly address the scope of these issues.

It should suffice here to review the latest mortality for the various Indian regions and to redirect some common approaches and understandings about alcohol and Indians. Therefore, the following data presentation will attempt to present mortality data in ways in which they are rarely addressed. The purpose is to raise the issue of adapting data collection and analysis most closely to the overall needs of prevention and social policy for broad and comprehensive community public health initiatives.

Alcohol and other drug abuse take a disproportionate toll among most groups of Indians and Alaska Natives in the Western United States as compared with both the United States averages and the average of the Western States in which Indians live. In table 9-1 some relevant and most current mortality data are summarized for Indians and Alaska Natives by age and sex-

specific categories. Without dwelling on the details in the text, one can conclude that the national Indian figures indicate higher rates of alcohol-related death for both Indian males and females in most age categories than found in United States averages. This is especially true for alcoholism deaths for both males and females in all age groups, but the ratio of Indian to non-Indian is highest in the ages before 45 years. Indian males have higher rates of death than Indian females for all types of alcohol-involved causes and in all age groups. Nevertheless, Indian females still have a substantial problem that cannot be ignored by prevention and treatment programs. For example, when Indian females aged 25 to 34 years are compared with non-Indian females for alcohol-involved causes, Indian females die 1.4 to 12.0 times more frequently, and chronic consumption is the most important style of drinking to address for improvement of female rates and causes of death.

Indian males also have higher rates of alcohol-involved death than other United States males in every age and cause category except suicide in the older age groups. In the age group 25–34, for example, Indian males die 2.8 times more frequently from motor vehicle crashes, 2.7 times more from other accidents, 2.0 more from suicide, 1.9 times more from homicide, and 6.8 times more frequently from alcoholism (alcohol dependence syndrome, alcoholic psychosis, and chronic liver disease and alcoholic cirrhosis). While these rates and ratios are insightful, they only tell part of the story that is useful for prevention planning.

In the far right-hand section of table 9-1, the **actual number of deaths** (not rates) from these causes is given for all Indians and Alaska Natives. For 1986 through 1988, motor vehicle and other accidents, suicide, homicide, and alcoholism caused 4,307 deaths for males and 1,474 deaths for females for a total of 5,781 deaths. Using an approximation of alcohol involvement that has been gleaned from the Indian and non-Indian alcohol literature (see May, 1989a, or May, 1992, for the methodology), the far right column provides an estimate of the extent of alcohol-involved death.³ A total of 2,705 male deaths and 951 female deaths are estimated to have been alcohol-involved in these three years. Of the total of 21,943 Indian and Alaska Native deaths from all

causes in these years, 17.5% were, therefore, alcohol-involved. The differential, however, is very great between Indian males and females. Among Indian males, 26.5% of all deaths were alcohol-involved, while it was 13.2% for females. This translates to a ratio of 2.84 alcohol-involved male deaths to 1 female death, which is twice the ratio for non-alcohol-involved death (1.42 to 1).

In summary of table 9-1, the reader can conclude that: Indian males have a greater problem with alcohol-involved death (both rates and absolute numbers) than Indian females; the alcohol-involved mortality data are worse for both Native males and females than for the average United States statistics for most every alcohol-involved cause; and the disparity between Indians and the United States general population is greatest in the younger age groups (see also May, 1989a, 1986). The need, therefore, for preventing alcohol-involved problems is one of a different magnitude, it has very different age and gender implications, and it may require slightly different approaches than among the general United States population.

In order to focus prevention efforts on priorities based on alcohol-related mortality, programs and funding would have to change from what they are today. Below, the data will help explicate the priorities as indicated by mortality data.

From the absolute number of deaths in table 9-1, the highest priorities for males of all ages would be alcohol-involved motor vehicle accidents (N=944) and alcoholism (N=649), with other problems ranked less important. For females the priorities would be the same, but the disparity between motor vehicle accident deaths and alcoholism deaths is not as great (1.25 to 1) as it is with males (1.45 to 1). Furthermore, using similar and much more detailed analyses for particular age groups or particular communities, one could target specific and delimited secondary and tertiary prevention much more precisely than it is usually done. For example, analysis of actual deaths among Indian males under 25 or even 35 years of age would certainly emphasize that alcohol-related accidents, suicides, and homicides are of far greater concern in number of deaths than are other alcohol-related causes. One must also keep in mind that in some Indian communities the data would indicate that the priorities should

*Alcoholism deaths include the following causes: alcohol dependence syndrome, alcoholic psychoses, and chronic liver disease and cirrhosis specified as alcoholic.

****Includes all Indian and Alaska Natives in all parts of the 32 reservation states served by IHS (total deaths in reservation states 1986-1988 = 21,943).

Source: Computed from U.S. Indian Health Service, 1991a.

[illegible]

be very different from the national Indian trends shown above. Local data analysis and planning are vital for tailoring of prevention programs.

To make a further distinction about the pattern of alcohol-involved mortality among Indians, table 9-2 is also concerned with the different causes of death by rate, number of deaths, and similar estimates of alcohol involvement applied to both Indians and the United States for 1986-88 and 1987 respectively. Considering the rates in the left-hand portion of table 9-2, one can see that the age-adjusted rates per 100,000 for United States Indians are higher (1.53 to 5.45) than general United States population rates for all five alcohol-involved causes. In fact, the overall rate for these five causes of death is 2.79 times that of the United States averages. In the middle section of table 9-2, the actual **number** of deaths for these causes is presented. For United States Indians the five causes that are frequently alcohol-involved accounted for 4,735 (17.2%) of all Indian deaths for 1986-1988. When the estimates of actual alcohol involvement from the far left column of the table are applied to each cause, the magnitude of alcohol involvement is 2,955 deaths, or 17.0% of all Indian mortality. This compares with the overall United States figures of 7.7% for the same causes and 4.7% estimated as definitely alcohol-related.⁴ Therefore, the alcohol-involved mortality, as measured by rate and as a percentage of all deaths, is currently a greater health problem in Indian Country. This is obviously consistent with sex-specific data presented in table 9-1.

The Indian Health Service, Office of Planning Evaluation and Legislation, in recent years has attempted to correct for possible misidentification of Indian deaths in some areas of the country by basing some of its data breakdowns on only 9 of the 12 service areas.⁵ This may yield a more accurate accounting of the true size of the problem as it exists in the more traditional reservation areas and isolated Western States. It may also be more representative of reservations and Native communities where conditions are different from major United States population concentrations, and where data are more complete. In the far right of table 9-2, these alternate data are presented. In these rates, deaths, and percentages based on the nine service areas, it is shown that the

ratio of alcohol-involved deaths (Indian vs. the United States population) is even higher than in the previous comparison (3.69), and the estimate of alcohol-involved deaths as a percent of total Indian deaths is 19.0% as compared to 4.7% for the overall United States population.

A final distinction from table 9-2 is very important for planning and prevention (see Westermeyer, 1976). This is the classification of different types or categories of alcohol-involved death (see also IOM, 1990). In the table, deaths are divided according to predominantly alcohol-abusive (sporadic alcohol use) and predominantly alcohol-specific (chronic alcoholism) deaths. Of the four causes of death listed in the upper part of the table, the alcohol-abusive causes (accidents, suicide, and homicide), are estimated to cause substantially more mortality than the alcohol-specific. In the total Indian comparison, the alcohol-abusive causes accounted for 2,213 deaths in 1986-1988, and the alcohol-specific caused 742 deaths. The percentages are: alcohol-abusive = 74.9%; alcohol-specific = 25.1% of all Indian alcohol-involved deaths. In the nine-area comparison the data are virtually the same: 1,678 (74.3%) for the alcohol-abusive and 580 (25.7%) for the alcohol-specific. In the general United States population (1987) the percentages are slightly different, 83.9% alcohol-abusive (N = 83,133) and 16.1% (N = 15,909) alcohol-specific (see table 9-2).

The real significance of the above data to prevention and intervention is great. The simple message is this: **Alcoholism** per se is not really the leading or number one health problem among Indians. *We would be much more accurate in stating that alcohol abuse and alcoholism (both sporadic and chronic consumption) combine to form the leading health problem among Indians.* If health and public health professionals and citizens focus solely on chronic alcohol consumptive behaviors (Indian anxiety drinkers), then up to three-fourths of the problem is ignored. This is also true for the overall United States population. *Prevention efforts, therefore, must embrace all alcoholic and alcohol-abusive behaviors.* Additionally, special prevention initiatives need to be aimed at the specific and particular characteristics of each type of alcohol-involved death. One cannot expect to improve all types of alco-

Table 9-2. Age-Adjusted Mortality (rates per 100,000) and Total Estimated Deaths* from Alcoholism** (Alcohol-Specific) and Alcohol-Abusive Causes for the U.S. General Population, 1987, and Indian Health Service Population, 1986-1988.

CAUSE OF DEATH	Estimated & Alcohol- Involved	All IHS Areas (Rate)	All U.S. (Rate)	Ratio IHS/ US	Total Indian Deaths (Number)	Total Indian Alcohol- Involved Deaths (Number)	Total U.S. Deaths (Number)	Total U.S. Alcohol- Involved Deaths (Number)	Nine IHS** Areas (Rate)	Ratio Nine Areas/U.S. (Rate)	Total Deaths in 9 Areas (Number)	Total Alcohol- Involved (Number)
ALCOHOL-ABUSIVE												
Accidents												
Motor Vehicle	65	57.5	19.5	2.95	1687	1087	48,290	31,389	75.2	3.89	1303	847
Other	25	45.5	15.2	2.99	1278	320	46,730	11,683	61.5	4.05	998	250
Suicide	75	17.9	11.7	1.53	534	401	30,798	23,099	22.8	1.95	403	302
Homicide	80	16.9	8.6	1.97	494	395	21,203	16,962	20.1	2.34	349	279
SUB-TOTAL												
(Abusive Deaths)	—	(137.8)	(55.0)	(2.51)	(3993)	(2213)	(147,021)	(83,133)	(179.6)	(3.26)	(3053)	(1678)
ALCOHOLISM**												
(Alcohol-Specific)	100	(32.7)	(6.0)	(5.45)	(742)	(742)	(15,909)	(15,909)	(45.8)	(7.63)	(580)	(580)
TOTAL												
(Abusive & Alcoholic)	—	170.5	61.0	2.79	4735	2955	162,930	99,042	225.4	3.69	3633	2258

SUMMARY OF ABOVE

Deaths as a
percent of
total deaths
(U.S. Total =
2,123,323
IHS = 17,409

9 Area IHS = 11,861

30.6% 19.0%

*Includes deaths of Indian and Alaska Natives only within those counties within reservation states where IHS maintains services. This, however, is the vast majority of all Indian deaths in Western States.

**Alcoholism deaths for both U.S. and I.H.S. rates include the following causes: Alcohol dependence syndrome, alcoholic psychoses, and chronic liver disease and cirrhosis specified as alcoholic.

***These nine areas are the ones which I.H.S. cites as not having major problems with under-reporting of Indian deaths. They are: Aberdeen (SD, ND, NE), Alaska (AK), Albuquerque (NM, CO), Bemidji (MN, MI), Billings (MT, WY), Nashville (ME, NY, NC, MS, FL, LA), Navajo (AZ, NM, UT), Phoenix (AZ, UT, NV) and Tucson Southern AZ). Not included in the nine areas because of reporting problems are: California (CA), Oklahoma (OK, KS) and Portland (WA, OR).

Source: *Computed from U.S. Indian Health Service (1991b).*

hol-involved death with a single type of initiative. Because alcohol-related problems are heterogeneous, multiple measures, techniques, and approaches of prevention and treatment are necessary to alleviate the extant problems.

The final table, table 9-3, presents data for the 12 different IHS service areas. This table could be considered a prototype for specific areas or specific communities to use for planning targeted prevention. It documents alcohol-involved causes by type, gives an estimate of the alcohol-relatedness of deaths in proportion to all deaths, and allows comparison of rates with the United States population and the total Indian population. Similar tables utilizing age and sex breakdown and local area-specific information, comparisons, calculations, analyses, and other considerations (e.g., types and locations of alcohol-involved crash deaths) could and should also be generated. Such local data constructions and analyses would be valuable for targeting specific prevention and intervention measures in a reservation or local community. Too often prevention efforts have not been built on the use of highly focused data, particularly locale-based data.

A summary of the significant information in table 9-3 is important. First, the areas vary widely in their experience with alcohol-involved mortality. The highest rates of alcohol-involved deaths are found in Tucson, Aberdeen, Phoenix, Navajo, and Billings, and the lowest in Oklahoma, California, and Nashville. Second, the areas have varying rates of the different kinds of deaths. For example, some have high rates of both alcohol-abusive and alcohol-specific (alcoholism) causes (Aberdeen, Albuquerque, Billings, Tucson, and Phoenix). Other areas (Nashville) have low rates of both alcohol-abusive and alcohol-specific deaths. Some other areas, as IHS reports indicate (1990), may be affected by under-reporting (California, Oklahoma, and Portland). Finally, others have an unequal mix of alcohol-abusive and alcohol-specific deaths (Alaska and Navajo), where the alcohol-abusive deaths far exceed the incidence of alcohol-specific. Third, the percentage of deaths that are alcohol-involved varies by area, from 8.3% to 22.4%. Therefore, variation in alcohol-involved behaviors does vary greatly from one reservation or community

to the next (see May, 1982, 1989a, 1992). Prevention efforts must adapt to these variations when planning for, or dealing with, alcohol problems from a community-wide, public health perspective.

Etiological Considerations Vital to Indian Prevention

Several variables have been explored to determine and explain the etiology of Indian rates and patterns of alcohol-involved behavior and mortality. Standard demographic variables explain some alcohol-involved problems in ways that tend to demystify Indian behavior and are therefore very useful for prevention.

First, factors such as the age of the population are very influential on alcohol-involved behavior. Because the average (median) age of the population of Indians in general, and particularly among some Western tribes, is below that of both the general United States population and the Western States, one would expect higher crude death rates from certain behavioral causes such as alcohol-involved accidents and violence (May, 1986, 1989a; May and Smith, 1988; Broudy and May, 1983; May, 1982b). Therefore the Indian causes of death reflect those typical of youthful populations. Prevention must therefore be geared to the high-risk peer clusters of younger Indian people. School-based programs only address part of the population and the problem, for the bulk of the morbidity, mortality, arrests, and problems occur among those who are not in school because of age and other reasons.

Second, most reservation and Western Indians (the bulk of the IHS service population) live in rural areas that have a low population density. This also elevates the rates of certain causes of death such as accidents and violence. Long distances to health care and emergency medical system response times in rural areas cause up to four times as much death from injuries as from similar injuries occurring close to a hospital (Waller, et al., 1964). Therefore, prevention in the environment needs to be addressed through highway engineering, motor vehicle policy, emergency medical care, health education programs appropriate for rural Indian lifestyles, and other issues.

Alcohol-Involved Deaths as a Percent of Total Deaths in Area (Rank)	17.0% 4.7%	16.7	14.8	22.4	12.9	19.6	12.2	23.1	8.3	22.3	19.3	20.9	
		(7)	(9)	(2)	(10)	(5)	(8)	(11)	(1)	(12)	(3)	(6)	(4)

*Alcoholism deaths for both U.S. and I.H.S. rates include the following causes: alcohol dependence syndrome, alcoholic psychoses, and chronic liver disease and cirrhosis specified as alcoholic.

**These nine areas are the ones which I.H.S. cites as not having major problems with under-reporting of Indian deaths. They are: Aberdeen (SD, ND, NE), Alaska (AK), Albuquerque (NM, CO), Bemidji (MN, MI), Billings (MT, WY), Nashville (ME, NY, NC, MS, FL, LA), Navajo (AZ, NM, UT), Phoenix (AZ, UT, NV) and Tucson (Southern AZ). Not included in the nine areas because of reporting problems are: California (CA), Oklahoma (OK, KS) and Portland (WA, OR).

Source: Computed from U.S. Indian Health Service (1991b).

Third, the cultural, social, and behavioral differences of the tribal and Indian sub-populations throughout the United States must also be considered, for they cause variance in the death patterns of some alcohol-related conditions such as cirrhosis of the liver, violence, and other causes of death (see Levy and Kunitz, 1974; Broudy and May, 1983; Katz and May, 1980; May, 1986, 1989a, 1989b; Van Winkle and May, 1986). As was shown in Tables 9-1-9-3, American Indian groups have different **patterns** of sickness and death for many alcohol-related causes from those of non-Indians. There is also aggregate variation between tribes and communities due to variations in particular social and cultural traits, norms, values, or laws.

Finally, and most important for this paper, alcohol policy directed at Indians has been rather unique. The historical influence of alcohol policy directed at Indians has produced particular patterns of drinking and mortality that are still evident today (Dozier, 1966; May, 1976, 1986, 1992). Knowing and understanding these factors are important in intervention and prevention planning. Etiological knowledge is very important and should be pursued as part of prevention activity. Gaining knowledge of cause, particularly as manifested in local Indian communities, is truly a key in picking and/or designing the proper prevention approaches. Without such knowledge, or a pursuit of such knowledge, prevention efforts or programs may not be effective. Furthermore, it is my experience that the pursuit of scientific notions of pattern, cause, and knowledge gain is very stimulating to prevention activities.

The above discussion of the problem of alcohol abuse among Indians is intended as a limited overview of mortality only. It is, however, one tailored to the needs of broadly focused prevention. Mortality provides excellent data for indicating problems from which to start prevention, for it is one of the few alcohol-involved outcomes that produce unduplicated counts.⁶ It is also a type of data which is quite complete and less complicated by agency or local peculiarities. Arrests, morbidity, and health and social service program data all have the problem of aggregating multiple episodes or visits for a limited number of individuals. The data generated by these individuals might

appear to be a much larger number and therefore a larger, less specific, and different problem than that which needs to be addressed.

Discussion: The Orientation and Content of a Community Alcohol Abuse Prevention Program

In closing this paper a summary discussion is in order. What should be done for the prevention of alcohol abuse in an Indian community? Mohatt and Blue (1982) relate the following anecdote:

Peter Kelly, Chief of the Sabaskong Reserve in northwestern Ontario, has concluded that everyone studies the Indian to find out what is wrong, but that nobody does anything about it.

The literature summarized in this paper shows that programs are attempting to do something about it. The goal of the future should be to undertake comprehensive, community-wide efforts for alcohol abuse prevention.

A Public Health Perspective

A comprehensive community approach to prevention must focus on a *public health perspective*. In a public health approach the goal is to apply comprehensive strategies and programs that reduce the rates of affliction and early death among total groups and aggregates of individuals (Beauchamp, 1980). Often the target would be all people on a particular reservation and in border towns nearby. The focus therefore is on communities and particular geographic areas and *not* on individuals. Further, no one type of alcohol abuse prevention should be championed, but various programs and approaches should fit together in a mutually supportive and beneficial manner (May, 1992). This is not unlike the analogy of a patchwork quilt. Therefore, primary, secondary, and tertiary levels of prevention dealing with a variety of the alcohol-involved behaviors would all be utilized and coordinated (see Manson, Tatum, and Dinges, 1982; Bloom, 1981; May, 1992). All of the various programs described in this paper, then, are

not at all mutually exclusive, but can be mutually supportive if orchestrated by a comprehensive community-wide plan and approach. Once the problems and priorities of a community are set from research, data analysis, and local wisdom, the proper set of programs and approaches can be established drawing heavily on the literature presented here. A community will want/need to have some prevention programs of all levels (primary, secondary, and tertiary) in place, along with health and drug abuse treatment programs. Communities will also need to plan for monitoring or evaluation the outcome of their efforts.

In the past there have been studies on how some Indian communities have been destroyed by adverse forms of modernization and change, and how alcoholism has served as a major co-factor in the negative process (Maynard and Twiss; 1970; Shkilnyk, 1985). On the other hand, Alkali Lake and other experiences raise the hope for, and expectations of, the healing process (Ward, 1984; Fox, et al., 1984; Macedo, 1988). Comprehensive alcohol abuse prevention programs can be a major vehicle in the process. Below is a summary of the general considerations that the literature cites as important in prevention among Indian communities.

Cultural and Local Community Relevance

Prevention programs that are carried out in Indian country must be designed in a way that allows the content of the program to be shaped and molded to fit the tribal culture. Further, prevention programs must help the tribe in their efforts of empowerment (Beauvais and LaBoueff, 1985). Prevention programs can be initiated by outside "experts" working with tribal leaders, but the continuation and entrenchment of the activities must be carried on by individuals in the local community (OSAP, 1990). This does not mean that prevention plans cannot be designed for one tribe and then transferred to others. It means that programs should be made relevant to local norms, values, and conditions through particular, culturally sensitive adaptations (May and Hymbaugh, 1989). Many adjustments made for a particular tribe

or community can be very minor, and, while cultural specificity is important, it need not be a total obstacle either theoretically or politically.

Policy Considerations

Alcohol and other drug abuse policy initiatives are approaches to prevention that have been infrequently addressed or tried in the past (May and Smith, 1988). Alcohol policies of prescription are extremely rare, for the norm on most reservations is self-imposed proscription (May, 1977). Most tribal alcohol statutes are not very specific in their provisions for the control and enforcement of alcohol or prescription of behavior once a person has been drinking. Further, the informal norms that surround drinking behavior in many Indian peer groups and communities are not serving the best interests of either individuals or the masses. Normative expectations, therefore, need to be considered in prevention efforts. Specific and detailed policy designed to shape alcohol-related behavior has rarely been undertaken for a variety of reasons (May, 1986, 1992). Because most reservations are under prohibition, alcohol prevention efforts such as dram shop laws, bartender training, strict license provisions, tribal mandates, and situational drinking norms have seldom or never been used or researched for Indians on reservations or in other rural areas (May, 1976). Policy measures will very strongly support other prevention initiatives such as those that address the socio-cultural values of youths and other targeted drinkers (Newcomb and Bentler, 1989).

Programs to prevent alcohol and drug abuse among Indians must address both sporadic and binge use as well as chronic consumption (May, 1989a). As the data in this paper showed, Indians suffer twice as many deaths from alcohol-related accidents, suicide, and homicide as they do from indicators of chronic consumption such as cirrhosis of the liver, alcohol dependence syndrome, and alcoholic psychosis (OTA, 1986; IHS, 1991b). But age-adjusted rates of death for both chronic and sporadic abusive causes are above national average rates. This is particularly true on some very high-risk reservations in the Western United States.

Therefore, the actual programs must be tailored to the conditions of the particular community.

Alcohol Issues for Females

Among neglected and growing problems that must be addressed by prevention programs in the future is that of female alcohol and drug use. Prevalence of female drinking is growing rapidly in some tribes, and has been relatively high in others for some time (May and Smith, 1988; May, 1989a; Whittaker, 1962; 1982). Consequently, the cirrhosis death rate of Indian females is now about 50% that of Indian males. But the danger is that female alcohol problems will remain unrecognized or unaddressed, as in the past, with both Indians and other groups. Female alcoholism, particularly among those of childbearing age, has very grave implications for the future of major Indian groups (Dorris, 1989).

The Drunken Indian Stereotype and Prevention

Health education and prevention programs carried out in Indian country should address issues that are currently shrouded in the myth of the "Drunken Indian Stereotype." Many components of the myth are inaccurate (Westermeyer, 1974; Leland, 1976), and therefore may impede productive prevention planning and efforts (May and Smith, 1988; May, 1992). Prevention efforts cannot embrace, or fail to deal with, the scientifically inaccurate idea that Indians are so different biologically, culturally, or in other ways that they cannot benefit from the experience of other human beings. This, however, is a great challenge, for in some tribes like the Navajo, a majority (63%) of the people believe that Indians have a special physiological weakness to the effects of alcohol (May and Smith, 1988). A major deficit in the rate of alcohol metabolism or any other particular physiological predisposition to alcohol abuse has never been documented in the scientific literature to date (see Schaefer, 1981; Reed, 1985; or May, 1989a, for reviews).

Dealing with such misconceptions in a prevention program facilitates the transfer of many ideas and approaches for preven-

tion. Once misconceptions and myth are examined with facts, many prevention strategies from mainstream and non-Indian populations can be transferred to Indian populations with only minor modification. As indicated in the literature review, many authors have concluded that social learning theory is quite generally applicable to solving problems of alcohol abuse among American Indian youths and adults (Bach and Bornstein, 1981; Winfree, et al., 1989; Sellers and Winfree, 1990). Knowledge and education-based programs that focus on correcting misconceptions and fostering new thinking about solutions are promising and may even be healing experiences (Beauvais and LaBoueff, 1985).

Indians generally know the negative consequences of alcohol quite well (May and Smith, 1988). But prevention efforts may have to work to reduce fatalism and to impart other, policy-relevant and action-specific information to initiate and entrench solutions. Prevention aimed at the presentation of knowledge on the adverse consequences of alcohol abuse alone will be of limited value. Prevention efforts designed to initiate specific, programmatic policy and community solutions are the thrust that might be taken in the future (OSAP, 1990). Prevention programs should begin with opinion and knowledge surveys of Indian adults in the target communities to assess the current conditions and traits. Then more relevant education and community-based programs will be forthcoming.

Strengthening Existing Institutions in Communities

A prevention program among Indians has to include plans for involving and strengthening the community and family. Indian families that are strong and well integrated produce children with better indicators of adjustment, and usually fewer indicators of deviance (Jensen, et al., 1977). Conversely, disorganized, multi-problem families have higher alcohol utilization and more health and deviance problems (Spivey, 1977; Lujan, et al., 1989). Community-wide programs can and must also serve to strengthen or mobilize a community in a number of ways.

Therefore, a complete prevention program in an Indian community must be built on the particular epidemiology of the area and be designed with local culture, norms, values, beliefs, and conditions in mind. Programs must aspire to research, understand, and decrease morbidity and mortality. Implementing programs of health education, policy initiatives, increasing community awareness of solutions, and initiatives designed to assist in norm clarification, definition, and prescription and proscription of behavior hold promise for prevention. Further, such efforts must be coordinated with a variety of health care and social service agencies, treatment programs, and criminal justice agencies.

Community mobilization, designed from within the community, seems to be the promise of the future in the prevention of alcohol and other drug abuse among Indians (May, Miller, and Wallerstein, in press). In spite of the extremely unfortunate treatment of Indians in North America in the past, most Indian communities have many cultural traditions, values, institutions, and structures that can add to or carry forward community-wide prevention initiatives. The research ideas and prevention techniques and proposals presented here can be meshed with tribal traditions to minimize the problems of alcohol abuse in the future.

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End Notes

1. **Primary prevention** is the promotion of health and elimination of alcohol abuse and its consequences through community-wide efforts, e.g., improving knowledge, the environment, and the social structure, norms, and values. **Secondary prevention** utilizes measures available to individuals and populations for early detection with high risk persons and groups (e.g., youth) and prompt and effective intervention to correct or minimize alcohol abuse in the earliest years of onset. **Tertiary prevention** consists of measures taken to reduce existing impairments and disabilities and minimize suffering caused by severe alcohol abuse or alcohol dependence (adapted from Last, 1983).
2. The reader who is even more interested in mental health issues, either independently or as they relate to drug abuse, should definitely consult Manson (1982) and OSAP (1990).
3. Actually this estimate may be conservative for Indians, for autopsy studies of motor accident victims that are in progress in New Mexico, by May, Bergdahl, Guerin, and others (See Bergdahl, 1991, and Guerin, 1991), show 70 to 85% alcohol involvement in Indian crashes. Further, other accidents might be 40% or more alcohol-involved in some areas.
4. Actually these estimates of alcohol involvement may overestimate U.S. alcohol-related deaths. For example, U.S. literature on suicide and homicide seldom indicates more than 50% alcohol-involvement for suicide or more than 70% for homicide. Further, motor vehicle accidents are usually reported as 50% alcohol-related in many states. Nevertheless, for consistency and to account for possible under-recording in various communities in the nation, these same alcohol-relatedness factors were used for both U.S. and U.S. Indian calculations.

5. These nine areas are: Aberdeen, Alaska, Albuquerque, Bemidji, Billings, Nashville, Navajo, Phoenix, and Tucson. Excluded are: California, Oklahoma, and Portland areas.
6. Mortality data for some causes of death and for states, cities and sub-populations of the United States might be less reliable than those produced for American Indians in western states. Factors such as incomplete or inaccurate classification of cause of death, missing data on alcohol relatedness, variation in coding by social class and other issues must be kept in mind and assessed when using mortality data from any group or community. Death data from the vital statistics should be cross-referenced with autopsy data, police data, state records and other sources when possible.

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Native American Community Alcohol Prevention Research

Pamela Jumper Thurman

Introduction

Concern over the issue of American Indian alcohol and other drug use has stimulated a major interest on the part of researchers to identify successful and sensitive methods of prevention and treatment for this population. As a generally underserved and understudied population, American Indian communities are certainly in need of appropriate and responsive research models, measurement tools, and reliable data on the nature and extent of drug abuse. This paper will present the demographics of American Indians and Alaska Natives, briefly discuss the rather significant history that has resulted in the current Tribal and Native structures, present some information on the incidence and prevalence of drug abuse within this population, and discuss how these factors relate to the current state of collaboration between Native communities and researchers.

May (in this monograph) has provided a thorough demographic description of the American Indian population in the United States and makes it apparent that American Indians are a very diverse group of people. Frequently the majority culture tends to view American Indians and Alaska Natives as a homogeneous group—as “Indians” whose customs, beliefs, and tradi-

tions are very similar. However, this is most certainly not the case. American Indians and Alaska Natives are a highly diversified group of people with not only individual and family differences, but tribal and cultural differences that vary greatly from location to location, often even within the same geographic localities. For example, differences exist in appearance, clothing, customs and ceremonies, traditional practices, family roles, child rearing practices, beliefs, and attitudes. Each tribe, band, or Native village maintains a unique perception of the world both inside and outside of their particular area. Even within the same tribe, differences exist. Some Indians or Natives are very traditional in their beliefs, maintaining tribal languages, ceremonies and customs, while others may be more contemporary, holding to some Indian traditions while maintaining a successful orientation to non-Indian society as well.

One striking similarity shared by all American Indians and Alaska Natives is a long history of Federal or governmental control over Tribal/Native issues as well as control over many individual decisions. There have been major Federal attempts for removal of Indians and Natives from homelands, sterilization of women of child-bearing age, and relocation programs. Assimilation attempts have included legal efforts to stop various ceremonies and dances, restrictions on speaking Native languages, and again, relocation programs. Pamela Kalar (1992) states that "cultural insensitivity, voracious greed, paternalism and the bitter fruits of inept lawmaking have compounded the inequities suffered by Native peoples on and off the reservation." Often it is forgotten or overlooked that these "First Americans" were not given voting citizenship until 1924 in most States and not until 1946 for Arizona and New Mexico.

Even identification as an Indian can follow many different guidelines. There is no single definition of an Indian. Some tribes define by blood quantum, and others may use family or clan identification. There are also people who identify by level of acculturation or even self-identification as an American Indian. In fact, some institutions, such as schools, universities, or the United States Census (1990), accept self-identification as the factor that determines whether or not a person is American Indian

or Alaska Native. In some cases, even people who may be Indian by blood quantum may not be accepted by others in the tribe as "Indian." This ambiguity of definition affects legal issues and research agendas as well as individual situations.

Recent congressional actions have returned some power to Indian and Native Nations through legislation such as the Self Determination Act, Indian Education Act, and the Indian Child Welfare Act. Such mandates have begun to empower Indian people to the extent that many American Indians and Alaska Natives have involved themselves politically in major decision-making issues. There is, once again, an American Indian in the Senate, and many powerful political American Indian and Alaska Native role models.

However, it is significant to note that, although there have been political successes, sadly, there are still few economic successes. Many Native families still experience poor nutrition, live in substandard housing, and lack the resources necessary to provide their children with choices for positive opportunities.

Another encounter shared by most Native groups is the boarding school experience. From the late 1800's to the 1960's, church-affiliated boarding schools, in their attempts to successfully assimilate Indian people, literally terrorized many Native children. They were punished, often severely, for speaking their Native language, were humiliated in front of their peers, and received extreme hair cuts in an effort to conform to "White society." Although the Bureau of Indian Affairs still maintains several boarding schools, today's efforts are much improved from those earlier endeavors and, in fact, include cultural curriculum and employ many Native teachers and staff.

These historical events are discussed here only because they influence the current political and personal environment of American Indians and Alaska Natives; they are factors which must be considered when conducting research in these communities. If there is an aura of distrust, there are long-standing and solid historical reasons for those feelings.

American Indians and Alaska Natives still suffer from prejudice and lack of access to many of society's benefits. They have been targeted as having high rates of school dropout and poor

economic prospects. All of these factors are also believed to place them at high risk for drug abuse. It has also been speculated that when Natives live in rural towns and/or reservations, drug abuse problems may be even worse because there are so few effective local resources for either treatment or prevention.

American Indian Substance Use

Alcoholic beverages or spirits were relatively unknown to most American Indian tribes previous to European contact. The early 19th century brought numerous White traders into Indian territory. Alcohol may have been given to the Indians initially as a gesture of friendship. The Indians developed an attraction to these new "spirits" and, consequently, drunken behavior began to appear. Loss of control and an inclination to drink until the supply was exhausted were major characteristics of the Indians' initial drunken reactions to alcohol (Dozier, 1966). Because of the novelty of alcoholic beverages, tribes really had no established social patterns or codes for regulation of alcohol use. Additionally, there was an uncertainty about how to react to drunken behavior and whether or not to condone it, tolerate it, or ignore it.

In an effort to present some of the major theories behind drug abuse among American Indians, it is probably necessary to address the literature's references to the vision or dream quest and its similarity to alcohol inebriation (Carpenter, 1959), if only to acknowledge that some drugs are still used today for ceremonial purposes. Carpenter believed that Natives who adhered to the traditional beliefs often sought the state of inebriation because they equated it with the spiritual experience of the "vision quest." It is very difficult today, however, in any manner, to equate addiction or alcoholism/drug abuse with any religious or spiritual experience. In fact, contemporary users of traditional drugs such as peyote, tobacco, and mushrooms in ceremonies are radically opposed to illicit or recreational drug use. Natives who use drugs for religious purposes consider their use to be very ritualized and extremely controlled. Alcohol is disallowed at these prayer or healing ceremonies. For example, if it is discov-

ered that a plant, such as peyote, has been used incorrectly, rather than maintain that plant for future ceremonies, it is destroyed by the spiritual leader.

Incidence and Prevalence of Alcoholism

For those planning research endeavors in American Indian or Alaska Native communities, it may be helpful to recognize some of the challenges that will be encountered. Not only are there many tribal differences, but there are differences in the incidence and prevalence of drug abuse in Indian communities as well.

Given the tribal and village differences, it is not surprising that alcohol and drug use among Natives vary tremendously from one group to the next (May, 1982). May (1986) cites some tribes as having fewer drinking adults (30%) than the U.S. population (67%) while other tribal groups have more (69%–80%). For instance, in 1988, Juanita Learned of the Cheyenne Arapaho Tribes in Oklahoma (1990) indicated that there were 33.9 deaths (per 100,000 population) among American Indians in that region caused by alcohol dependence syndrome, alcoholic psychoses, and chronic liver disease and cirrhosis. This rate is 5.4 times greater than that of the Americans of all races dying from these same causes in 1988. Some even believe that these numbers are understated due to deaths occurring for reasons such as alcohol related injury, suicide or homicide. Certainly these data support the need for successful collaboration between the Native groups and the research community to clarify the true extent of the problem and design methodologies that would supply the valuable treatment and prevention information to significantly decrease these use statistics.

When considering the youthfulness of the American Indian and Alaska Native population, it seems necessary to include prevalence information specific to this group. It has been established that Indian youth use most every type of drug with greater frequency than non-Indian youth and that the age of first involvement with alcohol is younger for Indian children. The rates of drug use and involvement can even be two to three times higher

for American Indian youth than for Anglo youth (Beauvais, 1992).

Other research by Swaim (1991) in the area of risk factors for drug-abusing Indian youth has cited low family caring, poor school adjustment, weak family sanctions against drugs, positive attitudes toward alcohol use, and risk of school dropout. Literature is also consistent in the premise that drug abuse behavior is to a large extent influenced by cultural values and norms. Yet another risk factor that accounts for high use rates among Indian youth is a lack of educational and employment opportunity. When Indian youth begin to reach adulthood, they find few chances of securing decent jobs, limited educational opportunities, and scant resources for improving this situation. This lack of opportunity is difficult for these young people and may also be a contributing factor in the potential of alcohol and/or drug use. In these situations, getting high could certainly become more attractive than reality.

Research Challenges

These factors reflect only a portion of the challenges that many Native groups are experiencing. Often it may be preferable to Native entities to be ignored completely rather than continue to read about the negative aspects of being Native. It isn't difficult to realize why the presence of researchers within a Native community can be regarded with mistrust and sometimes even hostility when the resultant article presents problems which then eventually become associated with "all Indians." The problem areas and negative aspects receive the most attention while the majority of healthy successful Native families and what makes them that way are overlooked. It is imperative that all researchers:

- (1) view Natives as people of social equality, who are invested in developing their own problem statements and solutions;
- (2) respect Native culture and tradition;
- (3) acknowledge and collaborate with the Native Councils and persons of authority;
- (4) accept the concept of Tribal and Native diversity;
- (5) avoid generalizing findings in one Native community to all Native communities; and
- (6) contribute something of value to the Tribal quality of life.

Community/Researcher Collaboration

In reviewing an article by Joe Trimble (1977), it was realized how little the issues have really changed in 15 years. He indicated that scientists from a variety of disciplines have "poked their noses, notebooks, cameras, and videotape equipment in Indian communities." He lists as some of the major research problems: (1) little, if any, community or tribal participation in anything other than the data collection procedures, (2) findings that contribute to controversy, (3) the suspicion with which many Native communities view research, (4) intrusion into the culture, (5) lack of tribal policies regarding research endeavors, (6) results that contribute little to provide a basis for program development or problem solving, and (7) findings that are viewed in non-native theoretical frameworks. Trimble provided an excellent and thorough discussion of the many barriers that exist in building positive collaborative relationships between researchers and tribal or Native entities.

It is often very discouraging for tribes when one considers that much of what has been published about American Indians and Alaska Natives has proven to be more of a liability than an advantage and may even result in controversy. Since the design of most research strategies for American Indians and Alaska Natives usually explores problem areas, it is necessary to proceed with care; otherwise, it is possible to maintain negative stereotypes and to assume that Natives, as a whole, are consumed with nothing but problems. In reality, there are many healthy, successful Native families that are making a positive impact in their communities. Research findings could be presented in a way that they would contribute something back to the tribal community or village by including information that would (1) alter negative perceptions, (2) convey some message of hope, (3) raise awareness of other researchers, (4) build Native support, (5) increase positive images of Native people, and (6) assist in the development of programs that promote increased opportunities and self-sufficiency.

Characteristics of a Successful Research Collaboration

The Tri-ethnic Center for Prevention Research at Colorado State University recently implemented a pilot prevention project in a rural town in the United States. There is a significant American Indian population in this town and many students, Indian and non-Indian, reported high alcohol, marijuana, and other drug use. Because of this usage level and the school's willingness to participate, it was decided to initiate a pilot project that was community generated and culturally specific to the tribe living in that area.

Local data were collected regarding drug- and alcohol-related statistics. Lengthy discussion groups were held with school staff, parents, students, and tribal people to formulate a problem statement, define the issues to be explored, and develop strategies that might be successful for this specific group of students. The research staff participated strongly, but respectfully, in these discussions in an effort to maintain scientific integrity in the methodology and implementation of the project. It was determined that there was insufficient community cohesiveness to attack this problem, little parent involvement to encourage academic success of the children, and few activities for this somewhat isolated town to offer the students. It was also determined that the school and the Tri-ethnic Center could collaborate with a high potential for success. At that point, the group formulated the types of activities and strategies that were appropriate for their community. This type of involvement also seemed to promote community investment.

Measurement processes and data collection procedures were developed with great care and time lines were established. Only a very small amount of money (\$10,000) was allocated to this project in order to allow replication for similar areas with limited resources. The money was used for printing costs, materials, and supplies. A person from a nearby community with similar demographics was trained by center staff and used as the primary data collector because she could speak the Native language, was familiar with the type of community and the people in it, though

not personally acquainted with the target population, and she was Native and therefore knew the cultural norms.

The principal community/family event was a culturally focused dinner, a local Native activity involving traditional foods, games, storytelling, Native and non-Native dance, and music. The event also served as yet another primary data collection point. The community response was overwhelming! It was the largest turnout ever recorded in the history of the school. Parents had an opportunity to meet teachers on an informal basis, and all participants received prevention tips and information materials. Both cultures met and interacted in a successful event that could never have occurred without knowledge and respect of the culture and involvement of Native and community residents in the identification of the problem and potential solutions. The Tri-ethnic Center obtained valuable data on prevention in rural Native communities.

Some of the major research challenges in this project involved finding the people in the school system who were willing to take on additional activity planning without pay compensation. Teachers and counselors usually have a full work day, and to add additional tasks is difficult. Volunteer help to implement and supervise the activities was difficult to obtain during the first year; but, following the success of the major community event, many parents and teachers volunteered for year two. The researchers tried to adhere to the guidelines discussed earlier in this article: continuing efforts were made by research staff to make certain that something would be contributed back to the community; in presenting the data, negative perceptions were not perpetuated by over-generalizing, by presenting only the problem areas, or by using stereotypes. Finally, the outcome resulted in the development of a program that the local population could be sure would promote increased opportunities and self-sufficiency.

Mechanisms to Improve Access and Trust

Given the interest in American Indian and Alaska Native cultures as well as in other minorities, one would think that there would

be a fair amount of literature available on methods of conducting relevant studies in these communities. Yet, there is very little direction on the structural components of successful research endeavors. Certainly the prevalence and incidence of alcohol and other drug use in understudied populations has received attention, and the need for additional literature is also recognized. However, there continues to be a need for well trained ethnic/racial researchers with knowledge of working with special populations to serve as principal investigators, advisors, reviewers, advocates, and mentors.

Major institutions have already recognized this need and several commendable programs have been established. As one example, in 1986, the National Institute on Drug Abuse introduced the Minority Research Development Seminar Series, whose primary mission was to provide training opportunities to ethnic minorities. The program has had considerable impact on the growing number of competent ethnic/racial researchers. Certainly, programs such as this one should be continued and enhanced in an effort to expand the pool of accomplished scholars.

Major funding institutions can continue to enhance research with special populations through the development of new methodologies that are culturally relevant for special populations. For American Indians and Alaska Natives, such considerations might be given to (1) communication barriers, such as language, (2) cultural norms and standards, and (3) political circumstances and perceptions. The recognition of and respect for Tribal or Native Council resolutions is important when research is conducted on reservation lands. In fact, funding sources could consider making this a requirement for grant applicants planning research on reservation lands. An appointed advocate for the tribe or village could act on a consulting basis to the researcher in an effort to ensure cultural sensitivity. The use of tribal advocates or special tribal or village advisors might even be included on the review committees to ensure that awareness of and respect for cultural norms are appropriately addressed.

The tribes or villages to be researched have special challenges that must be addressed. There is concern that yet another intruder

is coming into the circle to tell them what's wrong with their tribe or village. Often appropriate consent is not obtained and sensitive information is not strictly guarded. Frequently, tribal members are used to collect sensitive data. One pitfall is that villages and reservation areas are small—the Native community, in fact, is quite small—and such information can involve relatives or friends. This lack of confidentiality can result in refusal to participate in research endeavors.

The researcher also faces special challenges. As Trimble (1977) pointed out, the researcher must engage in more personal involvement when researching American Indian or Alaska Native villages. The people want to know who the researcher is and why he or she is there. There have been many intruders on Native lands and, initially, the researcher will be just one more. The Natives may invite the researcher to dinner or to tea in an effort to learn more about the researcher. A refusal on the part of the researcher may even result in closed doors to the research endeavor. One must also know the culture; ensure appropriate and sensitive data collection; develop valid instruments; acknowledge, respect, and collaborate with the ongoing changing governmental situations; honor customs; and communicate effectively while producing rigorous science. In view of these challenges, it is necessary to develop appropriate initiatives that will temper good science with consideration of cultural differences. Researchers often arrive in Native communities, stay only for brief amounts of time, and fail to gain the full extent of information that might be needed to appropriately formulate the results. Even then, they may perceive their findings through a non-Native framework which can make the Natives appear dysfunctional, abnormal, or deviant. Often researchers are not trained to really listen to tribal or village concerns. They can be quite capable of communicating their own concerns for research purposes, yet fail to address the concerns of the population they are studying. It is imperative that researchers leave these communities something of value that can be utilized for program development. "Something of value" can be the practical recommendations resulting from the research endeavor. Finally, results for one tribe must not be generalized to all other Indian or Native

groups. Tribes and villages are extremely diverse; this fact must be recognized by anyone conducting research with special populations.

Specific Alcohol Prevention Intervention Issues

It is helpful to researchers to include a brief history of the Indian Health Service Alcoholism and Substance Abuse Program, since these entities have a multitude of data and are prominent in most Native areas. At some point, the researcher will probably find it necessary to communicate with the Indian Health Service to gather background data.

This group has been the primary funding source for alcohol intervention in most tribal areas. In 1986, the Anti-Drug Abuse Act was passed by Congress with a subtitle that focused on American Indians and Alaska Natives. This appropriation provided funds for tribal leaders and staff training on alcohol and substance abuser and mandated youth services in both community-based rehabilitation and aftercare, and adolescent regional treatment centers. It called for the development of Tribal Action Plans to address drug abuse. These events were important as they led to a recognition among tribes and villages that drug abuse was a problem to be dealt with and that there would be Federal support to assist in the challenge. This recognition had a great impact on the awareness level of tribal officials and focused efforts toward improved services and quality treatment.

Research Needs

It is essential, however, to recognize that treatment and prevention programs for American Indians and Alaska Natives must be improved. Additional research is needed on these programs. Most treatment programs are usually based on the 12-step concept, adhere strictly to a medical model, and are addiction focused. This creates a somewhat narrow approach to which many youth and women do not respond successfully in treatment. Though some improvements may have occurred, other

methods and approaches must be explored in order to effectively address the problem of drug abuse. Such research could add valuable information to meet the challenge of quality treatment for Indian and Native youth. Most of these programs are severely underfunded and yet could successfully collaborate with researchers to improve treatment/prevention services and contribute significantly to the alcohol and other drug use literature related to American Indians and Alaska Natives. Such efforts would provide another source for additional funding and begin a potentially successful collaboration that would benefit all concerned.

In conclusion, there will always be similarities within cultures as well as differences. Many problems are shared by all cultures—school dropout, alcohol-related deaths, suicides, homicides, poverty and lack of opportunity, and drug abuse. While many cultures share these challenges, they are of particular concern when they affect youth. American Indian and Alaska Native youth deserve to be a top research priority. We are losing far too many of these children to alcohol-related causes. It is imperative that we make every endeavor to focus our finest research efforts on this special population. Although its disheartening that we still face the same research problems that we did in 1977, we have made significant gains—more minorities are trained and practicing in research, Federal programs are focused on special populations, and researchers such as Oetting, Beauvais, Trimble, May, and Manson are serving as excellent mentors. We have challenges to meet, and we continue to gain the resources to meet them.

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11

American Indian Alcohol Prevention Research: A Community Advocate's Perspective

Jerry D. Stubben

Introduction

The prevention of alcohol abuse is the key factor in overcoming alcohol-related problems in American Indian communities, whether reservation, rural, or urban (May, 1992). Prevention modalities, techniques, beliefs, and values vary greatly from one American Indian community to the next. Conducting prevention research on American Indian populations requires a great deal of creative thinking. Many of the objective empirical techniques that may work with non-Indian populations may not prove valid or reliable in the measures of the effectiveness of American Indian community-based prevention programs (Thurman, 1992; May, 1992). This is so because many of these measures do not embrace the traditional beliefs, practices, history, and values of the American Indian community (Thurman, 1992).

This paper is written from the perspective of the American Indian by a community advocate and strategist interested in promoting the prevention of alcohol-related problems in the Indian community. The contents of this paper draw heavily from several sources and represent a synthesis of ideas from: (1) the

two preceding papers in this volume on American Indians (May, Thurman); (2) other papers presented at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Working Group on Alcohol Prevention Research in Ethnic Communities held in May 1992 and published in this volume; (3) discussion comments made by a variety of participants at the working group; (4) the experiences and research knowledge of the author, who is an advocate for community-based studies and programs to prevent alcohol-related problems in the American Indian community.

Current Use of Alcohol Among American Indians

Although American Indian drinking has received a great deal of attention for many years from a variety of people, prevention efforts have only begun to emerge in the past 20 years. The literature on prevalence of drug abuse among American Indians indicates that alcohol and other drug use vary tremendously from one tribe to the next (Levy and Kunitz, 1974; Heidenreich, 1976; Mail and McDonald, 1980; May, 1977, 1982, 1986; Oetting, et al., 1980, 1983). Some tribes have fewer drinking adults proportionately than the U.S. population, whereas other tribes have more drinkers (May, 1992). Drinking patterns within the tribe can vary as well, as in the case of the Navajo (Topper, 1985; May, 1992). The majority of Indian youth of most tribes report experimentation with alcohol and a higher percentage of Indian youth report use of marihuana than other U.S. youth, but there is a wide intertribal variation (Heidenreich, 1976; Edwards and Edwards, 1989). Misuse of inhalants is a greater problem among Indian than among other U.S. youth (May, 1986; Thurman, 1992).

Explanations for Indian alcoholism abound, but no single explanation can adequately account for all American Indian alcohol problems. The heterogeneity of the Indian population (tribal custom, degree of acculturation or urbanization, geographic isolation) has hampered or precluded drinking problem surveys which permit generalizations (Lex, 1985). The character of American Indian drinking—alternate binge drinking and abstinence, solitary vs. social drinking, relationships between drinking style

and acculturation, and adoption of anti-alcohol religious ideologies—are examples of typical foci of drinking ethnography (Aberle, 1966; MacAndrew and Edgerton, 1969; Levy and Kunitz, 1974; Heindenreich, 1976; Hill, 1990). The degree of cultural anxiety and variations in tribal custom and history have been offered as factors in differences in drinking patterns among tribes. Misuse of alcohol is seen as an expression of the level of anxiety within the community (Field, 1962; Topper, 1985).

Knowledge of the drug abuse history, drinking patterns, etc. within a community is essential to conducting prevention research or in the development of community-based prevention programs for that particular community. In addition, the historical knowledge of the particular tribe under study is needed. Examples include: (1) knowledge of the treaty relationship between the tribe and the Federal Government, (2) boarding school experiences, and (3) most important of all, knowledge of the degree of the role of the Federal Government in determining and approving policies affecting tribal life, including drug abuse prevention policy (May, Moran, Stubben, Thurman, this volume).

Such information can best be gathered by extensive and long-term on-site visits to the tribal community. Through such extended contact the researcher becomes experimentally familiar with the community (Gilbert, this volume). Consequently, this ongoing relationship allows for more acceptance of the researcher by the community (Moran, this volume). An in-depth knowledge of the community will also provide assurance to grant reviewers at NIAAA that those applicants who seek funding to conduct multi-tribal prevention studies are culturally competent researchers (Gilbert, this volume).

Culturally Competent Community-Based Prevention Among American Indians

The following section discusses community involvement in prevention programmatic delivery and research in the areas of com-

community resources, issues of biculturalism and program effectiveness. There was a general consensus at the working group that community-based prevention programs must involve the community in all aspects of the prevention process. Moran (this volume) identified a prevention program among the Salish and Kootenai Tribes that included cultural committees which advised both the prevention and treatment staffs. Such community involvement gave the community a strong sense of ownership of the programs. May (1992) also identified a high degree of involvement among the Navajo in prevention and treatment programs within the various communities on their reservation. Thurman (1992) offered evidence that such community involvement must also be a key component in prevention programs for urban Indians as well.

Community Resource Issues

Stubben (this volume) discussed several instances where community resources could be utilized to deal with communication and value differences in the development and implementation of prevention programs within American Indian communities. He compared community members to translators of community beliefs, norms, values, personal and tribal histories, and even language. The extended family and other cultural relationships in American Indian communities play crucial roles in aiding or abetting prevention programs utilized in such communities. What may seem to be a dysfunctional family relationship from the majority population (Western society) viewpoint may not be similarly viewed from the specific tribal viewpoint.

Community members are a valuable resource because they can identify and define the differences in values between the Indian and Western worlds that make it difficult for the Indian person to avoid conflict in his or her daily life and to maintain balance and harmony in one's life direction. Learning to cope in both worlds is what most Indians are asked to do, particularly the young and middle-aged (Nieto, 1992). This acculturation pressure promotes drug abuse (Beauvais and LaBoueff, 1985; Bobo, 1985; Walker and Kivlahan, 1984; Topper, 1985). Accultura-

tion is stressful (Topper, 1985), and alcohol, tobacco, and other drugs offer coping responses (Trimble, Bryan, and Padilla, 1985). Lack of adequate cultural and personal skills necessary to cope with acculturation increases the likelihood for alcohol and other drug misuse, particularly in adolescence and the early twenties (Mail, 1985).

Bicultural Pressures

American Indian prevention and treatment programs must cope with these bicultural pressures in assessing the needs of this special population because many of the prevention and treatment modalities that may seem appropriate for other populations are not appropriate for American Indians (NIAAA, 1986). Previous research has identified that psychological counseling and referral to Non-Indian Alcoholics Anonymous (AA) chapters that are traditional in white Anglo-American mainstream alcoholism treatment may not appeal to many American Indians because of AA's public disclosure of personal problems, dominant Anglo-American religious overtones, exclusion of nonalcoholics, and attempts to influence the behavior of others. Likewise, many of the risk indicators that are traditionally used to identify potential alcohol use among youth, such as academic failure, permissive parental practices, or extreme economic deprivation practices, may not be useful or may have to be culturally interpreted in the prediction of alcohol use among an American Indian population (Medicine, 1983; Colorado, 1985; May, 1986; NIAAA, 1986; Grob-smith, 1989; Poor Thunder, 1991; Stubben, 1992).

The problems and explanations of drug abuse among American Indian and Alaska Native people call for new approaches to preventive intervention. Conceptually, these approaches must take into account the impact of both the traditional and the modern cultures upon the individual and their use or misuse of drugs (May, 1986). LaFromboise (1982) identifies that alcohol and other drug problem prevention programs for American Indians must "blend the adaptive values and roles of both the culture in which one is raised and the culture by which one is surrounded" (p. 12). May (1986, 1992) identified that a shortcoming

of many such prevention programs is their inability to educate American Indians about the social and physical impact that misuse has upon the individual and community. Prevention "programs must aspire to research, understand and decrease morbidity and mortality" through "increased health education, policy initiatives, increased community awareness of solutions" (May, this volume). Such health education programs must elevate the knowledge of American Indians about alcohol and other drug misuse through increased use of both traditional tribal strengths and modern prevention and treatment modalities.

However, a basic concern exists as to whether a bicultural approach to contending with the dominant American culture is a viable option for Indian people. Biculturalism refers to dual modes of social behavior that are appropriately employed in different situations. Some Indian observers believe that a functionally effective bicultural lifestyle is a myth, that those who attempt to practice it will necessarily become ineffectively stranded between two cultures (Schinke, et al., 1986). They believe, for instance, that one lifestyle will necessarily replace the other (Leon, 1968) or that personal preference and commitment to one lifestyle will predominate (Charleston, 1980). Others, however, suggest that effective functioning in two cultures leads to greater self-actualization (Dinges, Yazzie, and Tollefson, 1974; LaFromboise, 1982; LaFromboise and Rowe, 1983; May, 1986).

In fact, previous research has identified that the better integrated one is to both Indian and modern systems, the less the susceptibility to drug misuse. Indians who have meaningful roles in both traditional and modern cultures have the lowest susceptibility to alcohol and other drug misuse. Those with highest risk for misuse are marginal to both Indian traditional and modern cultures (Ferguson, 1976; May, 1982, 1986, this volume; NIMH, 1986; Schinke, et al., 1986).

Nieto (1992) asserts that those who have reached full development in two cultures have reached a state of *additive multiculturalism* and enjoy cognitive advantages over monoculturals through a broader view of reality, feeling comfortable in a variety of settings, and multicultural flexibility (p. 271). The knowledge of two languages is a key factor in additive multiculturalism

and should be tested in terms of ability among prevention staff, participants, non-participants and the community. Wilson (1991) pointed out that children in the Loneman Schools on the Pine Ridge Reservation in South Dakota did better on achievement tests if they were taught in both Lakota and English.

Prevention programs face a similar dilemma. Previous research indicates that prevention programs based solely on an Indian person's identification with Indian culture, although having some effect, are weakened because they do not deal significantly enough with external acculturation problems, such as school performance or the legal system (Oetting, et al., 1989). On the other hand, in recent interviews Stubben (1992) found that the utilization of a cultural component in alcohol treatment among American Indians, such as a sweat lodge or talking circle, improved their chances for recovery nearly five times over the lack of such a cultural component. Those prevention (and/or treatment) programs that are marginal to both Indian traditional and modern prevention modalities have been found to have the greatest chance of failure (LaFromboise and Rowe, 1983; Oetting et al., 1989; Stubben, 1992).

Furthermore, research on incarcerated American Indians identifies the impact of cultural factors upon sobriety. The majority of Indian inmates who were incarcerated for alcohol-related crimes found sobriety through traditional practices, if available. Inmates who had little acquaintance with their ancestral traditions prior to their incarceration, as well as inmates whose traditional practices were intact, enjoy deep involvement in religious activities and cite this involvement as being primarily responsible for their commitment to maintain sobriety. Since gaining access to illegal drugs in prison does not pose as much of a problem as it would for youth or adults on many reservations, those who abstained from drug and alcohol use stated that they were motivated to do so through a religious commitment to the "good Red Road," to "walking with the Pipe," or "walking the Peyote Road" (Grobsmith, 1989). In South Dakota, the switch from AA-based group meetings to Red Road group meetings increased the attendance of the American Indian populations from 20% in previous AA meetings to 80% in Red Road meetings (Sanderson, 1991).

Program Effectiveness Issues

Research on the effectiveness of culturally competent drug abuse treatment programs indicates that treatment programs that reflect Indian culture and incorporate native religious beliefs seem to be meeting with more success than those that don't incorporate a cultural component (Mail and McDonald, 1980; Moran, this volume; Stubben, 1992). Hall (1986) documents the effectiveness of treatment programs which include the Sweat Lodge and Sun Dance. Hill (1990) described the preventive nature of the Native American Church, as did Slagle and Weibel-Orlando (1986) with the Indian Shaker Church and AA Curing Cults. Evaluating the impact of the integration of such culturally traditional prevention modalities into community-based prevention program needs to be emphasized in future alcohol prevention evaluation and research. Funding for evaluation research on such "alternative" methods of drug abuse prevention and treatment must become a priority in the near future. The importance of this issue was reaffirmed by the "Working Group" because of the fact that many American Indian community-based prevention and treatment programs are presently utilizing their own tribally based prevention and treatment techniques, and these must be evaluated in order to prove or disprove their validity.

In fact, many American Indian communities rely only on their own tribally based prevention practices or totally adjust external prevention programs to these practices. Culturally relevant evaluation will measure the validity of such tribally based/culturally competent programs and may increase the utilization of tribally based/culturally competent prevention programs among all American Indian communities.

Evaluations of tribally based programs must be conducted by culturally competent researchers. Researchers with no or even a limited degree of cultural competence may actually do more harm than good in evaluating such prevention programs, since their findings may be so value biased that they identify situations that do not actually exist.

For example, Moran (this volume) discussed an evaluation of a prevention program in the Barrow community of Alaska

that was contracted to outside, non-Indian researchers. After conducting their evaluation, the outside researchers presented their findings to a community steering committee that had initially assisted them with access to the community. A draft of the evaluation was circulated to the steering committee, who felt it was difficult to read, verbose, and ambiguous. Foulks (1989) explained that the draft was seen as imposing outside standards on the native society without reflecting attitudes and values of the community. After major attempts to rectify the aforementioned dilemma, the researchers made another major blunder when the researchers' findings were released by an external agency at a press conference in Philadelphia. The news release was picked up by the national wire services and received widespread and sensational coverage. The community was surprised and angered by the "unauthorized" public exposure which brought shame on the community. Access to further community information was denied, as a large segment of the community refused to participate further in the evaluation (Foulks, 1989).

An evaluation of prevention and treatment programs among the Salish and Kootenai tribes was directed by an American Indian researcher from a local university who had extensive experience in both alcohol-related research and in evaluating American Indian prevention programs among several different tribes. This evaluation obtained a vast amount of information from the community, due in part to the long-term relationship that the researcher had with the community. Important information was offered freely by the community to the researcher, who had become a trusted member of the community (Moran, 1992).

Culturally Competent Community-Based Prevention Research Among American Indians

May, Moran, Stubben and Thurman emphasize in this volume that the researcher who is not part of the community being studied, must recognize the effect of the researcher's own values and beliefs upon the research design, data collection instruments,

data collection, even data entry and research conclusions. For example, a researcher who adheres to the health education prevention model may overlook the effects of traditional healing practices upon community-based prevention programs. Bias is a major impediment to reliable and valid drug abuse research and evaluation.

Bias Issues

Further discussion among the members of the working group suggested that perhaps the most effective method to deal with bias is to include members of the community into every aspect of the research. In such a situation, the principal investigator would identify members of the community who possess the education necessary to understand and express opinions on the validity and reliability of the research design. This would be done in the early stages of the development of the research design.

An "academic bias" may come to exist in the selection process of the community members chosen to evaluate the research design and assist in the research. If the researcher cannot find a fellow scientist within the particular community, other community members can be found who possess the knowledge necessary to assist with the research design or any aspect of the research (May, Thurman, this volume). It means that the principal investigator and the funding agency must adjust their own beliefs and values in order to accommodate the beliefs and values of the community, particularly those beliefs associated with educational credentials (Stubben, 1992).

Two examples of value differences, cultural terminology and tribal hiring practices, add credence to the aforementioned value conflicts that may arise in culturally competent research. In terms of life experiences, Moran identified a similarity of knowledge, beliefs, value statements, and writing style. These were recognized by the American Indian participants among themselves from the papers submitted and discussions during the "Working Group" sessions. Other minority group members, however, did not pick up on these. An example is the utilization of particular words and phrases (such as termination, elder, eagle feather),

mannerisms, and even acknowledgment of geographic territory of each person's tribe. Other participants did not pick up on these.

The other example came from a non-Indian participant in the working group who spoke of how an American Indian community member who was in charge of hiring data collection personnel tended to hire his relatives. This tribal practice was in violation of the values of the researcher and the society at large. Yet, from a community view, it added validity to the research because the members of the community who were interviewed could see that the community member in charge of hiring was following the tribal practice of "taking care of one's family or clan." In many American Indian communities one's creditability in the community is judged by how one treats one's family or clan. If one's relatives are suffering, then how can that person be expected to care about the rest of the community? Such community beliefs and values need to be accounted for, or else the research data collected may be unreliable and/or invalid (Gilbert, May, Moran, Stubben, Thurman, this volume).

Issues of Norms and Practices

Community norms and practices in a particular American Indian community may not fit those of the community that the researcher has grown up in or presently lives in. An example of this was evidenced by a researcher who was conducting interviews among a group of Plains Indian tribes in regard to obesity. She went in asking questions about dietary habits, physical activity, and health information delivery. But after two months of questioning it was brought to her attention that being overweight was considered by some clans as a sign of successful living, having plenty of food. This thought process had evolved from the past, when food was scarce and had high value among the tribe (Stubben, 1993).

This researcher had great difficulty understanding how an "ancient" belief could influence eating habits among a fairly large segment of the tribes interviewed, even after years of health information that obesity is a health hazard had been delivered to tribal members by IHS and tribal health prevention programs. A further finding revealed that government commodities that

are distributed freely to and consumed by many tribal members are full of fat and high in calories. The researcher was eventually convinced by tribal members who assisted with and reviewed the research that she must report in her research findings that both past tribal beliefs and present government policies were the major reasons for the high level of obesity among these tribes. Obesity prevention programs among these tribes need to take into consideration past tribal beliefs when redesigning prevention programs (Stubben, 1993).

May (1992) noted in his paper and discussion that many times researchers go into an American Indian community with a view that everything is wrong and nobody is doing anything about it. May stated that this viewpoint is wrong and ignores the major changes that are occurring in American Indian communities all across this land in dealing with and conquering drug abuse. For example, socio-economic indicators utilized in other communities as indicators of drug abuse may not be as valid with American Indian communities. The values and even educational background of the researcher and evaluator may prevent them from adjusting their research to the particular epidemiology of the community, from seeing the positive aspects of the community, and the culturally specific practices that the community utilizes in dealing with drug abuse.

For example, Medicine (1983) wrote of the common practice among Lakota women to totally abstain from alcohol and other drugs for the rest of their lives after becoming a grandmother and reaching the high status of an elder. Researchers may have difficulty understanding how such events as becoming a grandparent or having a spiritual vision through ceremony could be considered as preventing drug abuse. Yet, such major events in an Indian person's life tend to prevent drug abuse more than other practices and models in many tribes and communities. A researcher without the cultural competence to understand such events may not recognize them or their significance in conducting a community-based prevention evaluation.

Research Issues

The use of community members in the design of the data collection instruments, data collection, and coding of data can

be very helpful. Community members who speak the language, understand physical movements and verbal reflection, and/or live with the community's beliefs, practices, and values daily can prevent the types of problems that make the results of the research invalid. In the use of community members as data collectors, the researcher must identify through community members (1) the respected members of the community to utilize, (2) tribal norms on disclosure of personal information, (3) intertribal disputes between families, bands, clans, (4) age and gender norms, and (5) the degree of assimilation among tribal members. Be flexible; some tribes may require a community meeting to introduce both the principal investigator and co-investigators and the community members involved in the research. At this community meeting other community members can be identified who may have to be included in the research team for success.

In conducting interviews, several techniques may be required. For example, the principal investigator should interview a sample of the community alone, then have interviewers from the community interview another sample, and then have the principal investigator and interviewers from the community interview another sample together. The results of these interviews should then be compared to identify value differences. In utilizing written, self-completion survey forms, a community member may have to be present while individuals are filling out such forms in order to answer questions about the questions or the form itself. Also, the research team should use different types of forms on different samples of the community. The survey forms should include questions that are community specific as well as the general questions utilized in most drug abuse research. The utilization of questions that identify the respondent's view of local culture, norms, and values may be more important than identifying his or her use of alcohol. For example, should the community have a bar? Do you personally know any bootleggers in your community? Is it all right for a tribal council member to drink alcohol? If a person has a problem with alcohol, where should they go for help? What is a sweat lodge ceremony?

Therefore, a complete prevention program in an American Indian community must be built on the particular epidemiology

of the area and designed with local beliefs, culture, norms, practices, traditions, values, and conditions in mind. Likewise, research on the effectiveness of such prevention programs must involve community members to as high a degree as possible in order to take into account the impact of such local beliefs, culture, norms, practices, traditions, values, and conditions on the prevention of drug abuse in the particular community under study (NIMH, 1986; Thurman, May, Moran, Stubben, this volume).

Although community members need to be involved in all aspects of the research, that does not mean that every area of the community is involved. Thus, research progress, findings, problems, and conclusions should be presented to the tribal governing body, elder councils, and other community groups in order to both inform and gather further information. Also, the principal investigator needs to make him or herself available to the community for informal conversations, gatherings, and meetings, etc., without being intrusive. In other words, if invited to community functions by a community member, the researcher should attend. If not invited, the researcher should stay away.

Any research that is conducted within American Indian communities should reward the community for its participation. Employment of tribal members in all aspects of the research can improve the economic condition of even a small segment of the tribe. Indirect costs to the community (staff time, office space, housing, community travel, utilities, knowledge that is not directly paid for, inconvenience, etc.) could be taken into account within the initial grant proposal. Funding for community gatherings such as pow-wows, dinner (cooked and served by community members), school events, community meetings, elder meal and gathering, give-away, awards, etc., should be included in each grant application. Also, some of the computer equipment, paper, books, etc. purchased through grant funds could stay in the community after the research is completed—possibly in the schools.

Although minority supplement grants are presently available for post-doctorate minority researchers, additional scholarship and mentorship funding for both undergraduate and graduate minority students could be included in or linked to present or future prevention grants. American Indian and non-Indian aca-

demics could identify members of the community or other American Indians who are presently or soon will be attending college who may be interested in seeking academic training in prevention and treatment research. Those who want to pursue an initial academic degree or go to graduate school could be offered scholarships to the academic institution(s) that receive Federal funding for prevention research among American Indian communities. As is the case with minority supplement grants, mentors should also be available at these institutions for these students.

Research projects among American Indian communities must be long-term commitments. One cannot learn from an American Indian community unless one is willing to expend the time to learn. Future funding of prevention research projects should be for a minimum of five years. Funding should be available for the principal investigator(s) and co-principal investigators, who are not community members, to either live in the community year round, with regular visits to their academic institution, or make extended visits in the community on a regular basis. Since some prevention research projects may require visits to more than one American Indian community, funding for prolonged stays in or visits to each community are necessary.

One recommendation that came out of the discussions of the "working group" was a need for researchers and prevention staff to have a total understanding of themselves before ever setting foot in an American Indian community. The following statement flowed throughout this discussion: "One must know one's own values and beliefs before one can understand the values and beliefs of another." In other words, it is important not only that the researcher or prevention specialist who works with an American Indian community attempt to be as culturally competent in regard to the community that he or she is working with, but also they must be culturally competent about their own heritage and cultural background (Moran, Stubben, Thurman, this volume).

In terms of future research, despite a strong theoretical base and the promising initial support for culturally competent prevention programs, several important dimensions of evaluation will be required to clarify the potential impact of such prevention programs (May, 1986, and May, 1992). First, culturally competent

prevention programs for American Indians have not been submitted to a randomized, controlled efficacy study with long-term followup evaluation of the impact of such programs on risk and protective factors for alcohol problems. Second, although studies on the impact of prevention programs on risk and protective factors have been conducted on American Indian populations (Mail and McDonald, 1980; May, 1986), prior assessment has not measured the impact of the cultural components of prevention programs for American Indians upon these risk and protective factors (LaFromboise, 1982). Third, there has not been controlled, comprehensive measurement as to the impact of culturally competent drug abuse prevention programs on community perspectives of alcohol misuse. Alcohol misuse does affect every American Indian community, yet little or no research has been conducted upon how the community deals with the prevention of drug abuse from its own cultural perspective (Flute, et al., 1985; Poor Thunder, 1991; Wilson, 1991). Fourth, there is a need to bring the research and tribal communities closer together in order to be able to accomplish the aforementioned objectives and to develop culturally competent prevention programs based upon culturally relevant research findings.

In conclusion, one research or prevention model will not accommodate the variety that exists within American Indian communities and among the people who inhabit them. American Indian tribes maintain their cultural differences in order to maintain themselves as Indians. That is why any research or prevention model that attempts to integrate the values, beliefs, or even medical practices of the non-Indian world into the community world view will fail (Stubben, 1992). The researcher or prevention professional must allow the American Indian community to adjust such models to fit their particular community. For, in doing so, the cultural uniqueness of the community continues, the tribe maintains its identity, the researcher obtains valid and reliable data, and the prevention program is a success (Thurman).

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12

The Prevention of Alcohol-Related Problems Among United States Hispanics: A Review Raul Caetano

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Introduction

Heavy drinking, alcohol dependence and alcohol-related problems are complex phenomena whose origin is rooted in a variety of individual, cultural and societal factors. Society's attempt to respond to these problems was for a long time based mainly on the provision of treatment for those in need. Recently, recognition of the complexity of these problems and increased acceptance of public health paradigms have made prevention intervention and prevention research an important part of the response to alcohol-related problems. For instance, in the mid-1970s the National Institute on Alcohol Abuse and Alcoholism (NIAAA) created a Prevention Division (Room, 1990), and in 1983 it funded a national center whose focus is prevention research. In 1988

NIAAA established a Prevention Research Branch within a new division of clinical and prevention research (Howard, 1990). In 1986 the Office of Substance Abuse Prevention (SAP) was created to provide federal leadership for prevention activities in the substance abuse area (Johnson, 1990).

Prevention activities and research have become more and more diverse and sophisticated, and a large and varied literature on this topic now exists. This literature has been reviewed by many, with reviews focusing on educational strategies (Blane, 1976; Moskowitz, 1989), media campaigns (Wallack, 1981, 1985; Hewitt and Blane, 1984), alcohol control measures (Bruun, et al., 1975), and community action projects (Giesbrecht, et al., 1990). This paper reviews a part of this literature, i.e., recent community studies directed at the prevention of alcohol-related problems among U.S. Hispanics. Three previous papers have had this focus, two discussing prevention among Mexican Americans (Ames and Mora, 1988; Gilbert and Cervantes, 1987) and a third discussing prevention and other responses to alcohol-related problems among Hispanics (Caetano, 1988).

This review is organized as follows: The first section describes characteristics of Hispanics' history in the U.S., their migration, demographic composition, cultural diversity, development of ethnic identity and acculturation. These historical and sociodemographic characteristics are important for understanding the culture in which Hispanics' drinking habits are rooted and for developing and implementing prevention interventions in this ethnic group. The second section reviews research findings on drinking patterns and alcohol problems among Hispanics, and discusses a framework for understanding drinking and problem drinking among Hispanics. The third section reviews community studies for the prevention of alcohol-related problems conducted among Hispanics, assessing the reasons for their success or failure. The fourth section discusses the evidence regarding the need for "culturally sensitivity" in prevention interventions, and its relationship to the effectiveness of such strategies. The fifth section suggests ways to disseminate research findings that can be used to prevent alcohol-related problems. Such review will, hopefully, provide subsidies for the continuing development of prevention research focused on Hispanics.

Hispanics in the United States: Origin, Migration, and Growth

Hispanics' presence in the Southwest of what is now the United States can be traced back to the 15th and 16th centuries. At that time land occupation was mainly done by Spanish expeditions in search of silver and gold. During the 17th and the initial part of the 18th century land occupation was done to develop mining, establish missions and Christianize the Indians, and to counteract foreign interests in the region. During the 1800s a series of important political events such as the Mexican war of independence, American expansion to the Southwest, and the U.S.- Mexican war changed the face of colonization. These political events resulted in 1848 in the treaty of Guadeloupe-Hidalgo between U.S. and Mexico and the annexation to the U.S. of what is now Arizona, California, Colorado, New Mexico and Texas, as well as parts of Utah and Nevada. Later, in 1853, an additional area of 45,535 miles was purchased from Mexico through the Gadsden Purchase, completing the present shape of the border between U.S. and Mexico. The annexation marks the beginning of the history of Hispanics as an ethnic minority group in the U.S.

According to Moore and Pachon (1976), there were approximately 75,000 individuals of Mexican background living in New Mexico, Texas, Arizona and California when the treaty of Guadeloupe-Hidalgo was signed. Loosley (1927) indicates that according to the U.S. Census of 1850 there were 6,454 Mexicans in California. Since 1850 the Hispanic population has grown at a larger pace than the U.S. general population through migration and a higher than average birth rate. Migration from Mexico and other Latin American countries waxed and waned throughout this century following economic fluctuations and changes in immigration policies. At times of economic expansion the immigrants were welcomed. At times of depression the reverse was true. Immigration activities to stop illegal entry, a phenomenon as old as the creation of the border between U.S. and Mexico, have also varied in intensity. During the mid-1950s, "Operation Wetback" was launched by the Immigration Service to stop ille-

gal entry into the country, resulting in the expelling of 3.8 million Mexicans from the U.S.

Nowadays, preliminary figures from the 1990 Census indicate that Hispanics constitute about 9% of the U.S. population (U.S. Bureau of the Census, 1991). Mexican Americans are the largest national group among Hispanics, followed by Puerto Ricans and then by Cuban Americans. Most Mexican Americans live in the Southwest, with Puerto Ricans concentrated in the New York area and Cuban Americans in Miami. However, there already are large populations of Mexican Americans living in the Midwest (e.g., Chicago), as there are considerable numbers of Central Americans in certain metropolitan areas (e.g., San Francisco).

The history of Puerto Ricans in the U.S., the second largest group of Hispanics, is as rich and complex as that of Mexican Americans. Puerto Ricans have, however, a particular characteristic that sets them aside from other Hispanic national groups. Given the political situation of Puerto Rico, they are all U.S. citizens independent of whether they are born in the U.S. mainland or in the island. Thus, they are not subject to the same immigration laws that govern the entry of other Hispanic national groups into the U.S. Cuban Americans' presence in the U.S. increased considerably after Fidel Castro's revolution in Cuba. That change in political regime brought a great number of Cubans to the U.S., many of whom were not poor and disenfranchised as the Mexican peasants who came to the Southwest, but belonged to the Cuban professional class. Subsequent migration waves have had a different socioeconomic characteristic. However, contrary to other immigrants from Latin America, Cuban Americans have always been seen by the Immigration Department as political rather than economic refugees, and as such have had an easier entry into the U.S.

Hispanics are therefore a very heterogeneous group. The culture they bring from their countries of origin marks the beginning of their life in the U.S. and the patterns of interaction that they will have with American culture. Contrary to the European immigrants that came to the U.S. around the turn of this century, many Hispanics are not Whites but "brown." This too has set

them apart from other immigrants, fostering discrimination which has helped to shape their history in the U.S. The heterogeneity of Hispanics in the U.S. has created a debate around the use of the word Hispanic as a common identifier to this ethnic group (Aday, et al., 1980; Giadello et al., 1983; Hayes-Bautista, 1980, 1983; Caetano, 1986a). Critics suggest that such a common label creates an illusion of cultural and social uniformity which leads to the development of uniform social and health policies that fail to respond adequately to the needs of U.S. Hispanics. This issue is of importance to the prevention field, and the question of whether prevention strategies need to address these cultural differences across different Hispanic national groups will be discussed below.

Ethnic Identity and Acculturation

Understanding the processes by which Hispanics and other ethnic/racial groups develop their sense of affiliation with ethnic culture, i.e., their ethnic identity, is an important step for conducting prevention research or implementing prevention strategies in ethnic/racial communities. Understanding the association between ethnic identity and acculturation to U.S. society is also important for this work.

Ethnic identity for those immigrant groups who came to the U.S. during the second part of the 19th century and the first decades of this century is said to have emerged more from these groups' experience of life in the U.S. than from some common identity brought from their homelands (Greeley, 1971; Wolf, 1984; Room, 1985). With regard to Hispanics this process is different. Most immigrants from Latin America come with a sense of their national origin, and their pattern of geographical distribution in the U.S. suggests a need to be with "their own." Ethnic identity for U.S.-born Hispanics follows a different process, being influenced by their experience of life in the U.S. vis-à-vis other ethnic groups and the majority society (Caetano and Medina Mora, 1988). Thus, in contrast with other immigrant groups in the U.S., Hispanics are not isolated from their culture of origin. This is especially true of Mexican Americans, for whom Mexico

is not an unreachable faraway mother country, but can be easily reached by car or even on foot, thus representing a continuous source of cultural reinforcement and renewal. The unrestricted movement of Puerto Ricans between the mainland and the island has a similar role in Puerto Rican life.

Discussions of ethnic identity for U.S. Hispanics, and in particular Mexican Americans, have been oriented around two ideas: Adherents of the "colonial analogy" think of Mexican Americans as a conquered people (Moore and Pachon, 1976; Alvarez, 1985) and believe that their experience of ethnic identity development is different from that of other ethnic groups in the U.S. Others (Padilla, 1985; Fishman, 1985; McLemore and Romo, 1985) argue that there were very few Mexicans living in the U.S. Southwest at the time of annexation to characterize Mexican Americans as a conquered people. They also argue that Mexican Americans do not see the Southwest as their "homeland" (Connor, 1985), a necessary condition for characterizing their status as a conquered people.

The existence of ethnic identity does not preclude the development of an overall American identity. McLemore and Romo (1985) talk about "alternate identities"; Fishman (1985) refers to mainstream (American) and sidestream ethnicity; and Gordon (1964) discusses the notion of ethnic identity layers. Yinger (1985) and Fishman (1985) suggest that the implementation of ethnic identity is to a great extent situational. Birth, death, marriage and relationships with parents and siblings seem to occur within the territory of ethnic groups. Religion and entertainment are also more connected with ethnic culture than work. Relationships with governmental institutions are largely non-ethnic. Educational and work-related activities may be ethnically enclosed, non-ethnic or mixed, depending on a variety of circumstances associated with the situations in which such activities occur. Social class attributes also color these activities. Gordon (1964) has introduced the concept of "ethclass" to represent what he believes to be the main orientation of an individual, that represented by a cross-section of ethnicity and class.

Within this framework, acculturation is a process by which Hispanics balance these layers of identity, adopting with varying

degrees of intensity the mores and values of the majority society. Thus, there can be acculturation to U.S. society in some areas of life but not in others. Personal factors as well as factors in the surrounding environment will contribute to these choices. Hispanics who come to the U.S. of their own choice may acculturate in a manner different from those who come because of political persecution in their homeland. Coming to live in East Los Angeles may lead to a different acculturation process than coming to live in Brownsville or Chicago. As will be seen below, acculturation is a strong determinant of alcohol use among Hispanics, and as such it also is an important factor to consider in prevention research.

Alcohol Use and Related Problems Among Hispanics

The alcohol literature on Hispanics has been the subject of a number of reviews (Alcocer, 1982; Caetano, 1983; Gilbert and Cervantes, 1987). This section reviews the main epidemiological findings which suggest target groups for prevention interventions among Hispanics. Much of the review is based on findings from the 1984 national survey of Hispanics conducted by the Alcohol Research Group. The findings from the analyses of this survey have been reported in a series of papers, and have been recently summarized by Caetano (1991).

Drinking Patterns Among Men

Among Hispanic men the drinking pattern which is more closely related to alcohol problems and which should be the focus for prevention is frequent heavy drinking (drinking five or more drinks on occasion at least once a week). Hispanic men have a 12-month rate of frequent heavy drinking lower than that for non-Hispanic men in the U.S. population (17% versus 24%). Most of this frequent heavy drinking among Hispanics occurs among men 30–39 years of age (26%), while among non-Hispanic men in the U.S. the peak of heavy drinking occurs in the 18–29 age group. Analyses by national groups show that Mexican American men drink more than Puerto Ricans and Cuban Americans. Mexi-

can American men also have a higher proportion than men in the U.S. population who report drinking five or more drinks at a sitting (54% versus 42%). Other predictors of heavier drinking among Hispanic men are: having at least high school education, making \$30,000 or more annually, being acculturated, being born in the U.S., and being separated or divorced.

A proportion of the drinking done by Hispanic men is done in parks, streets and parking lots (26% of the men report drinking in these places). The mean number of drinks consumed in these public places is higher among Hispanics than among Whites and Blacks (Hispanics, 4.0; Whites, 3.1; Blacks, 2.5). The proportion of men who drink five or more drinks in these public settings is also higher among Hispanics than among Whites (Hispanics, 7%; Whites, 2%; Blacks, 7%). The settings where heavier drinking is most common are bars and parties. Men who go at least three times a month to bars or public places such as parking lots and parks tend to be single and younger than other men. These men also have a higher rate of heavy drinking and drunkenness than other men.

Drinking Problems Among Men

About 18% of Hispanic men reported at least one alcohol problem in the past 12 months. Men in their 50s, those with some high school education, those with annual income lower than \$30,000, those who are separated or divorced and those who are heavier drinkers report more problems than other men. Among U.S.-born men, those who are first generation report more problems than others. Among foreign-born men, Mexicans report more problems than others. The most frequent problems are salience of drinking behavior, problems with spouse, problems with other people, impaired control and health problems. Data on arrests indicate that Hispanics are overrepresented among individuals arrested for drunk driving (Caetano, 1984; Ross, et al., 1991). Mortality data suggest that Hispanics have a high rate of deaths due to cirrhosis (Caetano, 1986b).

Drinking Patterns Among Women

Hispanic women have a higher rate of abstinence than non-Hispanic women (46% versus 36%) and a lower rate of frequent

heavy drinking (2% versus 6%). Among Hispanic women, those in their 50s have the highest rate of frequent heavy drinking (8%). Among non-Hispanic women, the peak for frequent heavy drinking occurs among women 30–39 years of age (10%). The predictors of heavier drinking among Hispanic women are: being employed, having completed high school education or more, and being acculturated.¹ Mexican American women have a rate of frequent high maximum drinking (12%) higher than that of women in the other two major national groups (Puerto Ricans, 3%; Cuban Americans, 7%). This higher rate of heavier drinking seems to be due to drinking done by Mexican American women who are U.S.-born and who are highly acculturated to the U.S. About 38% of these women (N=95) are frequent high maximum drinkers.

Drinking Problems Among Women

Because they drink little, Hispanic women report few problems in comparison to men. The proportion of women reporting one or more problems in the past 12 months is 6%. Mexican American women and those who are U.S.-born report more problems than other women. Problems with highest prevalence are: salience of drinking behavior (3%); impaired control over drinking (3%); belligerence (3%); health problems (3%). Among Hispanic women, those who are single and those who are younger have a greater chance of having problems than other Hispanic women.

Norms and Attitudes Toward Drinking

Mexican Americans and Puerto Ricans have more liberal attitudes toward drinking and drunkenness than Cuban Americans. When norms are examined with regard to how much drinking is seen as appropriate for men and women in different age groups, there is considerable agreement that those who are 30 or 40 years of age may drink more than others. With regard to norms concerned with drinking larger quantities of alcohol ("drinking enough to feel the effects"), more Mexican Americans express approval of this type of drinking than Puerto Ricans or Cuban Americans. This is in accordance with Mexican Ameri-

cans' higher rate of heavier drinking and with their attitudes toward drunkenness.

Drinking Patterns and Problems

The results reviewed suggest that Hispanics who are in the upper socioeconomic groups drink more than others, but problems are more common among Hispanics with lower income. For Hispanics, drinking is seen as an activity that rewards the fulfillment of family and work obligations of men who are in full adulthood and beyond. Yet, much drinking still occurs among young men in their twenties. Some of this drinking by men occurs in public places, on occasions when the amount of alcohol ingested is relatively high. Ingestion of such high amounts is more common among Mexican Americans than among Puerto Ricans and Cuban Americans. Employment and birth in the U.S. seem particularly important in lowering abstention and increasing rates of heavier drinking among women. When women who are employed are compared with homemakers, the effect of employment on abstention is independent of age and education. Income may certainly play a part in these differences, but the Hispanic woman who works is breaking away from tradition as well as from behaviors, such as abstention, that may be associated with it.

Acculturation to U.S. society also plays an important part in shaping women's drinking. Women who are highly acculturated have 9 times greater chance of being heavier drinkers than do women in the low acculturation group. Acculturation also implies more liberal attitudes toward alcohol use and increased social opportunities to drink. Hispanics who are highly acculturated report more frequent attendance at a number of social settings where alcohol is often consumed (restaurants, clubs, bars, parties, home) as well as greater frequencies of drinking in these places. In general, these relationships are independent of income or work status.

The change in drinking patterns associated with acculturation seems to occur more quickly for men than for women. After 1 to 5 years of life in the U.S., men in the Mexican American group who were born in Mexico already had changed drinking

patterns from infrequent drinking of larger amounts to more frequent drinking of such amounts, which made their drinking similar to that of U.S.-born men. Among women, the change in drinking patterns described above only occurs among those born in the U.S.

These findings provide a series of subsidies for prevention. The obvious primary target group for prevention should be men in their twenties and thirties, unmarried and in lower education and lower income groups. Liberal attitudes toward the ingestion of large amounts of alcohol and de facto drinking of large amounts per occasion should also be minimized, especially among Mexican Americans. Drinking in public places should also be targeted for prevention. This type of drinking is more visible, may lead to public disturbance more easily, and is done with less control than drinking at home, in bars or restaurants.

The target group among women is that formed by women in their fifties, married, employed, more educated, born in the U.S. and more acculturated to U.S. society. Changing demographics, with an increase in the number of U.S.-born women and increasing entry of women into the work force, may lead to higher rates of drinking and alcohol problems.

Community Studies for the Prevention of Alcohol-Related Problems Among Hispanics

Long gone are the days when the response to alcohol problems in the community was based mostly on secondary prevention, i.e., the provision of treatment for individuals with alcohol problems. Prevention efforts nowadays are substantially more sophisticated, having shifted from a focus on alcoholics, roughly 7% of the general population who have been identified as alcohol abusers/dependent (Helzer, et al., 1991), to all alcohol-related problems. Prevention strategies have also shifted from a narrow focus on increasing knowledge about alcohol problems in school-based populations to a multi-pronged approach which emphasizes the need for community involvement and interventions at

a variety of levels: education, price manipulation, taxation, control in the number of alcohol outlets in the community, hours of sale, minimum drinking age, advertisement (Wittman, 1985; Bruun, et al., 1975; Holder and Stoil, 1988). These approaches have been suggested as suitable strategies for preventing alcohol problems in the population in general and among ethnic/racial groups such as Hispanics (Ames and Mora, 1988; Gilbert and Cervantes, 1987; Caetano, 1988).

Unfortunately, however, prevention interventions directed at Hispanic communities still lag behind other prevention activities. The same can be said of prevention research directed at U.S. Hispanics. Thus, assessments of the effectiveness of interventions such as school-based education, raising the minimum drinking age, administrative revocation of driving licenses, beverage containers with warning messages and others have all provided results which may not be applicable to Hispanics or other ethnic/racial groups. For instance, administrative revocation of license only works if individuals are driving with licenses. If, as seems to be the case with adolescent Hispanics, they drive without license, such strategies cannot be adopted as a prevention approach or will be less effective than otherwise. Studies of price elasticity, per capita consumption and its relation to changes in alcohol availability have not been directed at minorities either.

Ames and Mora (1988) were able to find nine prevention programs directed at Hispanics, most of which were education interventions directed at children and adolescents. All projects had made an effort to develop interventions that were culturally sensitive, having the family as their central theme, developing bilingual material, and one utilizing a "fotonovela" to disseminate information. Some of these projects were also discussed by Austin and Gilbert (1989), who also noted the lack of systematic evaluations of these interventions. As a result of the scarcity of ethnic-specific prevention research directed at Hispanics, the few existing efforts at evaluation are reviewed over and over again. Thus, Gilbert and Cervantes (1987) identified Caetano's (1982) evaluation of the Winners Campaign in California as the only existing evaluation of a prevention project directed at Hispanics. Ames and Mora (1988) reached the same conclusion, and at the

time of this writing that statement is still valid with regard to large community-based efforts.

Caetano (1982) described the outcome of a mass media and community organization alcohol prevention effort directed at Hispanics living in selected communities in the East Bay of San Francisco. The interventions consisted of a media campaign and community efforts. The media campaign used television and radio spots especially developed for the prevention intervention. The community efforts involved small group discussions and the distribution of leaflets, a prevention newspaper, calendars, bumper-stickers and automobile decals. Outdoor posters were also used to disseminate campaign messages. The evaluation followed a quasi-experimental design with two experimental sites and one control. One of the experimental communities received media and community interventions; the second experimental site received media messages only. Data were collected in three general population surveys of the communities in question before, during and after the interventions.

The evaluation objectives were to assess increases in community awareness of alcohol dangers, changes in attitudes toward alcohol consumption and changes in drinking behavior. Results failed to show consistent changes in most areas, with some areas (attitudes) showing inconsistent changes throughout the project time, and which were therefore difficult to evaluate. Exposure, recognition and recall of television and radio spots in Spanish could not be evaluated due to limitations of the evaluation process. For those spots aired in English, exposure, recall and recognition of television spots and campaign themes were low. In spite of its failure to promote changes in drinking behavior, the campaign had many innovative aspects. It was the first time that a mass media effort was especially designed to prevent alcohol problems, and broadcasting time was purchased so that television and radio messages could be aired at hours during which the target audiences would be reached. The design had limitations, but the choice of experimental and control communities, plus the before and after data collection efforts, created a powerful methodology for evaluation. But perhaps the most important lesson to be learned from this evaluation is that well-designed

prevention research directed at Hispanic communities can be conducted.

What are the reasons for this lack of prevention research directed at Hispanics at a time when epidemiological research and public health professionals have identified target groups with high prevalence of alcohol problems, a variety of prevention approaches that could be applied to Hispanic communities are available, and support has also been made available by federal agencies such as the National Institute on Alcohol Abuse? First, it seems important to separate demonstration programs from prevention research. These are independent enterprises, which require different skills and training for implementation. Nowadays there seem to be many more demonstration programs than research, and the reasons why this is so are complex. It seems, however, that most of the professionals involved in service provision and demonstration programs lack the training to develop and implement sophisticated research designs necessary to evaluate prevention interventions.

The situation becomes particularly acute with regard to research among minorities. Methodological designs and data collection efforts require extra steps when research is conducted among ethnic minority groups. Sample design needs to take into account oversampling, to obtain enough numbers of respondents in ethnic/racial groups; data collection needs extra time; questionnaires need to be appropriately translated in the group's language; and interviewers need to be bilingual and have adequate training to interview minorities. Ethnic/racial professionals, who may be more inclined than others to conduct such research and overcome these additional difficulties, are underrepresented among researchers in general as well as among those dedicated to prevention research. Non-ethnic/racial researchers either lack the interest to conduct research with ethnic groups or are intimidated by the lack of ethnic match between themselves and their subjects. There seems to be an unspoken rule that in order to conduct research on ethnic groups one needs to be "ethnic," too. Approaches to generate more prevention research in Hispanic communities include training of minority researchers and stimulating the transfer of knowledge between researchers and service providers.

Prevention, Cultural Sensitivity, and Competence

Like all other ethnic groups in the U.S., Hispanics have a unique culture, rooted both in that of the Latin American countries from which they originate and in their experience of life in the U.S. This culture sets them apart from the rest of the population, and suggests a need for prevention interventions and research that is specifically directed at U.S. Hispanics. Recent times have seen this need for ethnic-specific approaches challenged both in the areas of treatment and prevention research. With regard to treatment, the discussion has focused on whether it is necessary to provide ethnic-specific programs, i.e., programs that cater only to members of a certain ethnic group, or whether any program will do, once minimal attention to client characteristics are fulfilled (Institute of Medicine, 1990). In the prevention field the need for cultural sensitivity seems more acute, and some of this need is inherent to the nature of prevention strategies. Many times such strategies are not directed at the individual but at the community. It is essential, then, to be aware of community "ways" to be effective.

Prevention interventions directed at reducing alcohol demand through mass media campaigns are a good example of the need for cultural sensitivity. These messages need to be disseminated in the language of the ethnic group and at a level that will allow easy apprehension of message content. The content of the messages needs to be culturally appropriate, and the media used must be ones that will guarantee penetrance of the message in the community. Recent information from an AIDS campaign in San Francisco indicates that among Hispanics, celebrities are seen as less credible sources of information than physicians, clinical personnel and people with AIDS. These issues as applied to Hispanics have been recently discussed by Johnson and Delgado (1989).

However, the debate around the need for culturally sensitive interventions has yet to be framed in specific terms. A good first step in that direction will be to achieve agreement on what is

meant by cultural sensitivity. How "specific" or "different" do the interventions promoted among ethnic/racial population need to be from those promoted among the majority population? Full and accurate answers to this and other similar questions regarding a variety of prevention strategies can only be answered empirically, i.e., by conducting comparative studies of effectiveness across ethnic groups. The present lack of evidence should not be taken as proof that culturally sensitive or ethnic-specific interventions are not necessary or do not work. The lack of research results in addressing the effectiveness of these interventions is at par with that about prevention interventions in general. Only by funding culturally sensitive and ethnic-specific prevention efforts and by attaching to these efforts the requirement to conduct methodologically sound evaluation research will it be possible to answer the questions about effectiveness of prevention strategies among minorities. In spite of its limitations, the design employed by the evaluation of the Winners campaign in California is a good example of the prevention research that can be conducted among minorities. This design included data collection with Hispanics selected at random from the communities receiving the intervention and from the control community. These individuals were interviewed with standardized questionnaires by trained interviewers before, during and after the prevention intervention was implemented.

In the meantime, lacking information on the effectiveness of interventions, the best guess seems to be that some degree of cultural sensitivity is necessary, and the more sensitive the intervention is the more specific it will also be. The impact of cultural sensitivity on effectiveness may also vary from strategy to strategy. In the case of mass media campaigns it would probably be larger than in the case of price manipulation. Mass media campaigns need to pay attention to a series of aspects of communication (vehicle, language, etc.) that are not present in a strategy such as price increases. In this latter case, interventions are usually implemented through legislative action and are directed at more than one community, knowledge of local mores and customs is not so necessary as assurance of population understanding of the reasons for such action.

Culturally sensitive or specific prevention interventions can only be developed, implemented and evaluated by researchers who are culturally sensitive and competent to work in ethnic/racial communities. Cultural sensitivity has been defined as "awareness of the nuances of one's own and other cultures" (Orlandi, et al., 1992). Cultural competence is present when researchers have academic and interpersonal skills which allow them to appreciate and understand cultural differences and similarities across cultural groups. There should also be a willingness to conduct research work that is supported by "community-based values, traditions and customs, and to work with knowledgeable persons of and from the community in developing focused interventions, communications and other support" (Orlandi, et al., 1992). These characteristics can and should be developed by researchers independent of their ethnic/racial status, so that no ethnic match between researchers and community is necessary for the development and implementation of effective prevention interventions and evaluation.

Disseminating Research Findings

There has been considerable discussion of the barriers in disseminating research findings to advance treatment and prevention interventions in the community. The separation between research and treatment (Kalb and Propper, 1976; Johns, 1988; Ogborne, 1988), the success and failure of community action projects (Giesbrecht, et al., 1990), the evaluation of prevention strategies in the community (Goodstadt, 1990), the dissemination of alcohol knowledge with educational purposes (Newman, unknown), and means to increase the exchange of information among prevention researchers and the community (Giesbrecht, et al., 1990) have been discussed in the literature.

This literature suggests that the key aspect in disseminating results of prevention research is creating effective reciprocal communication between researchers and community agencies, community leaders and others interested in prevention intervention (e.g., community developers, planners, activists, grass-root groups). Recently, a group of prevention researchers (see Gies-

brecht, et al., 1990) proposed a model of communication that addresses the exchange of general information about prevention and the dissemination of findings that are specific to certain projects in the community. They also proposed a series of specific recommendations to enhance communication, which in summary are:

- Identify interested individuals, engage these individuals in all stages of the project, provide feedback, develop empathy and respect for these individuals.
- Be available to community groups to discuss prevention findings.
- Listen to community experiences and needs in designing research.
- Spell out the implications of research, describing in the final report how research findings can be applied in the community.
- Document the process of project development, enroll in training on how to respond to media, and be willing to reinterpret research findings to non-researchers and make recommendations.
- Actively promote successful interventions and produce reports suitable for dissemination of knowledge to non-researchers.

These well-thought-out recommendations should be applicable to the dissemination of prevention research findings in Hispanic communities as well. The need to identify key players and key community organizations, as well as the need to create effective communication channels with the community remain the same. Some particularities applicable to Hispanic communities, however, may exist. The community leaders or the community organizations involved in the process may change. Thus, the Catholic church or certain ethnic organizations may play a more important role in Hispanic communities than in other communities. Language barriers may be more of a problem in Hispanic communities, and research reports produced in English may also have to appear in Spanish.

Dissemination of research knowledge should be based on a flow of information between researchers and the community.

Researchers should listen to community needs and community plans for action if those exist, and at the same time provide information that can be used in new areas of community action. For example, Hispanic and other ethnic/racial communities have been the target of special advertisement efforts by the alcohol industry (Maxwell and Jacobson, 1989), and guidelines for citizen action to control such advertisements have been published (e.g., McMahon and Taylor, 1990). Providing information to Hispanic communities about prevention efforts that will respond to particular problems such as advertisement targeting is therefore part of an effective communication flow.

The development of guidelines for describing community planning for the prevention of alcohol problems is an effective way to communicate prevention research findings. A number of such guidelines exist, focusing on prevention strategies for community groups (Minister of Health-Ontario, 1988), college drinking (Upcraft and Welty, 1990), prevention among youth (NIAAA, 1991a; Oyemade and Brandon-Monye, 1990; Goplerud, 1991), women (NIAAA, 1991b), alcohol control strategies (Wittman and Shane, 1988) and control of alcohol billboard advertising (McMahon and Taylor, 1990). Suggestions regarding the basic format for such guidelines have also been put forward (Giesbrecht, et al., 1990). Unfortunately, none of these guidelines addressed alcohol prevention in Hispanic communities. McMahon and Taylor's (1990) handbook on strategies to control advertising emphasizes actions by ethnic/racial communities, providing special information about billboards in Black and Hispanic communities as well as information about drinking and minorities. Most of the strategies proposed in these guidelines should work well with Hispanics, but a resource guide in English and Spanish especially directed to Hispanics would perhaps have a higher penetrance and effectiveness than these general publications.

Conclusions

Hispanics constitute an important ethnic minority group in the U.S. Their presence in the country goes back almost 500 years.

They have a characteristic history in the U.S., marked by historical events as varied as the colonization of the American West, political events in Cuba, the special political relationship between the U.S. and Puerto Rico, and continuous immigration. Recent epidemiological research has identified Hispanics as a group at high risk for developing alcohol problems. Such research has also identified subgroups of Hispanics who are at special risk for developing alcohol problems as well as particular problems which have a high prevalence in this group.

These epidemiological findings suggest that Hispanics are a target group for prevention interventions. Yet, little systematic information on prevention programs directed at Hispanics and on the effectiveness of the existing interventions is available in the literature. Questions related to the need and value of "cultural sensitivity" in developing prevention interventions among Hispanics can only be answered in relation to the strategy under consideration: The relationship between effectiveness and cultural sensitivity is bound to vary from intervention to intervention. It will probably be stronger in those strategies directed at decreasing alcohol demand through education, and weaker in those strategies based on decreasing alcohol availability such as price manipulation through taxation. The lack of prevention evaluation research directed at Hispanics does not seem to be due to lack of interest from funding sources. One of the main reasons for the dearth of research seems to be the lack of Hispanic professionals with expertise in conducting such research. It is therefore important not only to maintain the existing funding opportunities for prevention research, but also to step up efforts to attract and train Hispanic professionals in prevention research.

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End Note

1. The scale used to measure acculturation has been described in detail by Caetano. Briefly, the scale was built with twelve items assessing daily use and ability to speak, read and write English and Spanish; preference for media in English or Spanish; ethnicity of the people respondents interacted with in their church, parties, and neighborhood now and when growing up, as well as questions about values thought to be characteristic of the Hispanic way of life.

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Alcohol Abuse Prevention Research in the Hispanic Community

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Introduction

Although there are many differences in the behavioral norms and values among Hispanic Americans of different nationalities, different generations and different socioeconomic groups, certain values, beliefs and customs are maintained within this population. It is this set of commonly held values, beliefs, and customs that forms Hispanic culture. Variations in drinking practices between racial and ethnic groups reflect *cultural differences* in the values, beliefs and customs ascribed to alcohol by different groups. The intent of this chapter is to discuss the impact of Hispanic cultural factors on conducting community-based alcohol prevention research.

Culture, Family, and the Community

Researchers and mental health professionals agree the concept of family lies at the heart of what is considered Hispanic "culture." Family rules which are endorsed by "the traditional Mexican family" were identified by several investigators some years ago (Montiel, 1973; Murillo, 1971; Romano, 1968). As described by these researchers, such cultural family rules appear to have been functional in securing the survival of large, traditional, lower class agrarian Mexican family systems. Such family systems emphasized family unity and a cooperative division of labor. A traditional family system offered protection in exchange for family loyalty. It emphasized family harmony and cooperation while discouraging individualism, competition, confrontation, and the open expression of anger. In this hierarchical system, family tasks and roles were divided by age and gender, with elders holding positions of authority and influence while children were obligated to obey elders under all circumstances. Males were encouraged to be *macho*, to express family pride, dominance, authoritarianism, and discipline, whereas females were encouraged to be *señoritas/señoras*, to care for children, serve male needs, and show deference toward males while also expecting protection from them (Carrillo, 1982; Falicov, 1982). More recently, specific changes within the traditional Hispanic family system have been described within a life-events change model (Padilla, Cervantes, Maldonado and Garcia, 1988). The traditional Hispanic family constellation has given way to various economic and acculturative demands. Increased demands for change within the family system have been shown to adversely affect individual mental health functioning (Cervantes, Padilla and Salgado de Snyder, 1991).

While generalized descriptions tend to capture the "flavor" of traditional Hispanic family values and normative rules, one must remember that *the* traditional Hispanic family is an abstraction, an exaggerated and therefore inaccurate version of what various Mexican American, Puerto Rican, Cuban, and Central

American families believe and practice today. Falicov (1982) has noted, in this regard, that broad generalizations such as these do not do justice to regional, generational, social class and other variations in family lifestyles observable across Hispanic families today.

Even within a given Mexican American family system, striking contrasts are often evident. One family member may identify strongly with these traditional family values, thus being highly motivated to comply with these cultural rules. By contrast, another family member who disagrees strongly may be highly motivated to actively oppose compliance with many of these cultural normative rules. Consequently, sibling or generational family coalitions may emerge, partitioning the family unit into factional groups (Goldenberg and Goldenberg, 1980). Children may strongly oppose the traditional cultural rules espoused by parents, and some immigrant parents may not fully understand the strong socialization influences affecting school-age children in the United States. Whereas traditional rules and standards for behavior have helped Mexican family systems maintain cultural identity, today, when a family member expresses a strict adherence to these rules that are out of context with majority culture demands, this strict adherence is likely to create stress for other family members (Cervantes and Castro, 1985).

Currently, most Hispanic family systems function as sources of identity, self-worth, and social support for their members by emphasizing *familism*, a family orientation that encourages family unity, the fostering of strong emotional ties between family members, and strong reciprocal kinship obligations (Bengston, 1976; Grebler, Moore and Guzman, 1970; Nall and Speilberg, 1967; Sotomayor, 1982; Vega, Hough, and Romero, 1983). Strong familism may help individual family members cope with social pressures that originate outside the family (Hoppe and Heller, 1975), including peer pressure.

Differences in the importance placed on family values can also vary. An isolated Mexican immigrant accustomed to receiving frequent emotional, tangible and informational support from a large, closely knit family system will likely experience distress during a period of isolation from that family system (Melville,

1978). Another immigrant seeking emancipation from such family closeness and perceived intrusiveness may find the isolation of a new environment much less distressing (Keefe, Padilla, and Carlos, 1979).

Studies of the help-seeking behavior of Mexican Americans both within and outside the extended family system report a process of differential help seeking by generational level. These have important implications for prevention researchers. First generation Mexican immigrants tend to have smaller extended family networks that the immigrant consults sparingly. By contrast, second and third generation Mexican Americans tend to have larger extended family networks (Keefe, 1980). While having larger, more diverse family networks, second and third generation Mexican Americans also have other support resources: friends, neighbors, clergy, and community institutions, thus having more of a choice in where to turn during times of need (Keefe, Padilla, and Carlos, 1979; Griffith and Villavicencio, 1984). Escobar and Randolph (1982) have distinguished between *open* family networks that are composed of many loose or weak connections and *closed* family networks that are composed of a few strong connections. They assert that traditional Hispanic families have maintained closed family networks although the process of acculturation has eroded the traditional family structure, including the strength of these family bonds. Weakening of family bonds has been associated with increased risk of alcohol and other substance use in youth.

As an example, Santisteban and Szapocznik (1982) found that Cuban families at greater risk for drug abuse include a son who is ashamed of and rejects his culture of origin. These youths strive to become *Americanized* while the mother is described as traditional in her cultural beliefs and shows neurotic patterns of behavior including the abuse of sedatives or tranquilizers. Such families become fragmented by many family conflicts, both cultural and non-cultural, and tend to consist of an overly involved mother and a father who is distant, absent, and provides inconsistent punishment. These investigators have concluded that the most adaptive survival strategy for various Hispanic families faced with intergenerational acculturative stressors involves

adjusting to the prevailing environmental milieu. Members of families needing to survive in a monocultural environment could avoid maladjustment by developing monocultural skills congruent with that environment, whereas those families living in bicultural environments would do well to develop bicultural skills congruent with their culture of origin and with the demands of the host environment. In other words, according to Santisteban and Szapocznik (1982), individuals living in bicultural environments tend to become maladjusted when they remain monocultural, although the relationship between acculturation and psychological impairment is admittedly a complex one (Griffith, 1983).

To summarize, strong family values and customs have traditionally characterized Hispanic culture. Research has only recently shed some light on the impact of social, economic, and acculturative demands on Hispanic families residing in the United States. Alcohol prevention research must attend to the complexities of Hispanic families and the role of acculturation demands that may pose special risks for Hispanic family members. Much research on such family-related risk factors is needed so that alcohol prevention studies may best target these family variables.

Culture and Religion

Religion has historically played an important role in the lives of Hispanic American families, with most Hispanics being Catholic. Family life cycle events in traditional Hispanic families are usually centered around the Catholic church and include traditions/rituals such as the baptism, first communion, confirmation, quinceanera (female's 15th birthday celebration), marriage, and death. Suffering and self-sacrifice are important and strong religious values that are transmitted to Hispanic families through the Catholic church. Maintaining an attitude of acceptance toward one's suffering is perceived as virtuous behavior and becomes part of the predetermination philosophy taken by many Hispanics (e.g., "what is meant to be will be"). Self-sacrifice is also thought to be directly related to spiritual rewards in the

afterlife (going to heaven; having eternal life). Such beliefs among traditional Hispanics are strong and can affect how illnesses, behavior disorders (including alcoholism), and personal shortcomings are dealt with by family and friends. In a discussion of alcohol treatment for Mexican Americans, Gilbert and Cervantes (1986) conclude that some families may endure male alcohol abuse beyond the extent to which the alcoholic's health and occupation are adversely affected. Male alcohol abuse may only be defined as problematic by the family when nuclear and extended family *relationships* are severely impacted. Prayer is often seen as an important solution to such family problems.

The Catholic church has historically played a central role in the lives of Hispanics. Not only has it provided spiritual and moral guidance, but it has been an important source of social support. Interestingly, however, the social support needs of Hispanics are increasingly not being met by the Catholic church. This may be due to its large size and its impersonal nature. Consequently, many immigrant Hispanics are now turning to smaller Evangelical churches through which the social support needs of this population are more likely to be met. Developing appropriate and effective prevention and intervention programs for Hispanics should consider the factors mentioned above. Specifically, the role of the family and the Catholic church in shaping the values of Hispanics needs to be considered and incorporated into the development of prevention programs and the design of intervention strategies. By taking this approach, the integrity of this population's cultural identity is likely to be maintained and/or enhanced. This, in turn, is likely to improve a program's effectiveness.

Brief Description of Alcohol Use

In 1985, approximately 87% of high school seniors reported to have used alcohol in the past year, and approximately 69% were currently using alcohol (Adams, 1986). These rates illustrate the prevalence of alcohol use in late adolescence, yet alcohol use can start early in life. Research by the National Institute on Drug Abuse has shown that 8.4% of United States children start to

use alcohol as early as the sixth grade (Johnston, O'Malley, and Beckman, 1987).

Membership in different ethnocultural groups is an important factor that differentiates patterns of alcohol and other drug abuse in the United States population. For instance, a 1975 National Survey of Adolescent Drinking Patterns found that Anglo American adolescents are the heaviest drinkers (75 percent), followed by American Indians (73 percent), "Spanish Americans" (68 percent), and African Americans (59 percent) (reported in Office for Substance Abuse Prevention, 1990). Patterns of different drugs used also varied by ethnocultural groups.

The 1986 National Institute on Drug Abuse (NIDA) Household Survey (1987) reports that although the use of alcohol and other drugs by adolescent African American and Hispanic females is lower than that of adolescent Anglo American females, rates of cocaine use are similar for Anglo and Hispanic females. Additionally, NIDA reports that lifetime prevalence rates of inhalants was slightly higher for Anglo females than for either Hispanic or African American adolescent females.

Drug use patterns also differ between different Hispanic subgroups. According to the 1987 Hispanic Health and Nutrition Examination Survey (H-HANES, 1987), 31 percent of Mexican Americans aged 12 to 17 reported some lifetime use of marijuana compared to 26 percent of Puerto Rican youth of similar age. Of all Cuban Americans aged 12 to 24, 21 percent reported having used marijuana at some time in their lives. Specific differences in alcohol use patterns among Hispanics by subgroup and gender were found by Caetano (1985). For example, Mexican American females had an alcohol abstention rate of 71%, followed by Cuban females (48%), and Puerto Rican females (45%). Less frequent and light drinking (i.e., drinking one to three times per month and never having more than five drinks at one sitting) is more prevalent among Puerto Rican (41%) and Cuban males (41%). Mexican males (12%) and third generation, or more, males (14%) are found to engage in frequent low maximum drinking (i.e., drinks more than once a week but never takes more than five drinks per sitting) more often than Mexican females. United States-born Mexican American females (26%) are more likely to

engage in frequent and high maximum drinking (i.e., respondent drinks once a week or more and has five or more drinks per sitting when compared with other subgroups of Hispanic females). Mexican males (23%) also were found to have high rates of frequent high maximum drinking, followed by the United States-born second generation males. Lastly, United States-born Hispanic males (35%) and Mexican-born males (19%) are just as likely to engage in frequent heavy drinking (i.e., respondent drinks five or more drinks per sitting once a week or more often). Overall, the current body of epidemiological research shows that males of Mexican heritage are at risk for developing problems associated with excessive and frequent alcohol abuse.

Although adult Mexican American males engage in heavier drinking behavior than Anglo American males, Mexican American adolescents and youth engage in less drinking behavior than Anglo American adolescents and youth (Caetano, 1987). It follows, then, that there must be a set of factors that interact in leading to the problem of alcohol abuse in adult Mexican Americans. First, it is generally permissible for adult males to drink heavily. As mentioned previously, some Hispanic families may tolerate heavy problem drinking beyond the point where it creates health and occupational difficulties. Secondly, adult male support systems can encourage drinking to facilitate social interactions that serve as informal information and support networks. "Machismo" (i.e., the pride a man feels toward his own masculinity) may also play a role in male drinking behavior. Strong group pressure for adult Hispanic males to demonstrate their masculinity by engaging in alcohol consumption has been found (Ames and Mora, 1988; Cervantes, Gilbert, Salgado de Snyder, and Padilla, 1990).

Besides those factors outlined above, it is possible that acculturation stressors experienced in some Hispanic households lead to the use of familiar coping techniques for reduction of tension, including alcohol use. For Mexican American males this may be manifested in turning to a male support group where drinking is considered normative behavior. Such stressors include language barriers, chronic unemployment, and unexpected shifts in gender role behaviors.

Previous Prevention Efforts

Given the risk for alcohol abuse among some Hispanic subgroups, and the number of factors that interact in contributing to alcohol abuse, prevention interventions are best designed when they target multiple risk and resiliency factors. The "Ganadores" program is one such attempt, through which a culturally sensitive mass media and community organization alcohol prevention program was implemented with a sample of Spanish-speaking persons in three California communities (Ames and Mora, 1988; Caetano, 1982). In this program, two communities were exposed to the media campaigns; one site included community organizing in its intervention. The third site served as a control where no interventions were implemented. The evaluation results of the program indicated no changes in drinking behavior, attitudes, and alcohol problems in either the overall sample or the Spanish-speaking subsample (Ames and Mora, 1988; Caetano, 1982). Reasons for the lack of success may include duration of the intervention, lack of reading skills of the target community, and insufficient inclusion of target families, schools, and churches in the design of the program.

Another program through which interventions were aimed at the school environment, as well as youth at risk for delinquent behavior, resulted in a small reduction in delinquent behavior and misconduct (Gottfredson, 1986). Gottfredson reports that students in the participating schools were suspended less often, reported fewer punishing experiences in school, and reported less involvement in delinquent and drug-related activities. It appears that in this program the environmental interventions promoted a sense of belonging and attachment to the school that played a role in decreasing delinquent behaviors. Similar results have been found in a prevention program targeted at 15 communities that make up the Kansas City metropolitan area. This program includes mass media programming, a school-based education program for youth, parent education and organization, community organization, and health policy components. The results of this program indicate that prevalence rates for drug abuse were reduced and that the program is effective for both

high-risk and low-risk adolescents (Anderson, et al., 1990; Pentz, et al., 1989). The multifactor approach of these programs ensures that the problem of drug abuse is addressed at various levels, and includes each institution that has contact with youth.

Specific Alcohol Prevention Issues for Hispanics

Cultural sensitivity is important in the development of prevention and intervention programs targeted at culturally diverse populations. Specifically, it is necessary to understand how membership in given cultural groups influences attitudes and behaviors. According to Gibbs and Huang (1989), ethnicity affects how mental health and illness are defined, it affects how symptoms are manifested, it determines help-seeking patterns, it is a factor that shapes response to treatment, and ethnicity likely influences the receptiveness to prevention programs. It is, therefore, important for researchers to understand the culture of the population targeted. In developing Hispanic prevention projects, care must be taken to understand the cultural nuances of a given community in terms of language, generational status of the target group, and level of acculturation. Prevention programs or prevention messages that fail to take these variables into account will likely result in small changes regarding expected outcomes.

In addition to developing prevention research strategies that are culturally and linguistically relevant for the target community, building a sense of trust and mutual collaboration within the Hispanic community is essential. Historically, researchers have been viewed as outsiders whose only interests have been in the furthering of academic careers. Further, many community members express resentment at study findings that portray the Hispanic community as having many social, economic and health problems. Results that describe ethnic communities as such may only worsen long-held stereotypes without addressing the many strengths (e.g., resiliency factors) inherent in these communities. Apart from this, many researchers have ignored the need for community members to be involved in the various phases of prevention research, including the planning and implementation

of these projects. Historically, the lack of developing such community linkages has resulted in a basic mistrust of university-based researchers desiring to conduct research in Hispanic communities.

Community Connections

Successful community-based prevention research efforts for Hispanics require establishment of key connections in the target community. Prevention research studies are likely to be successful if the researcher can connect with various institutions that serve Hispanic *families*, including schools, the church, and health service agencies. To the extent that linkages can be developed with such institutions, there will be greater acceptance and "buy-in" by the Hispanic community. Such linkages have proven successful in community-based alcohol and mental health research by this author (Cervantes, Gilbert, Salgado de Snyder, Padilla, 1990; Cervantes, Padilla, and Salgado de Snyder, 1991) where local churches and adult education centers provided an entree to the target samples. If such institutions can serve as co-sponsors of a prevention study, many barriers related to mistrust can be overcome.

Connecting with the target community must also involve a process by which community members are engaged in the planning of prevention studies. Focus group meetings, key informant interviews and community forums may provide an important opportunity for Hispanic community representatives to give input into the actual design of a project such that a prevention trial can successfully be accomplished. This process can strengthen the researcher/community relationship, thereby ensuring a successful research effort, especially if a liaison person or persons can be trained and become part of the actual research team. Such community liaisons can actually serve to bridge the research project with the community, as well as overcome any additional feelings of mistrust or suspiciousness regarding the research team. This may be a very *critical* component to the research where the research director or research team members are not Hispanic. Of course scientific rigor will only be main-

tained when the researcher makes final decisions regarding specific design and methodologic considerations.

A successful connection between researcher and the community will benefit from a process of open communication where information exchange occurs on a regular basis.

Conclusions

Planning and implementing alcohol prevention research in Hispanic communities must consider a variety of factors that will affect the research process. An understanding of the heterogeneity of the culture, the values placed on family and religion, and variations in acculturation must be incorporated into the design of such studies. Studies that recognize the importance of community risk and resiliency factors, particularly for Hispanic youth, are greatly needed in furthering our understanding of the processes that result in excessive alcohol use. These studies are greatly facilitated through a process that involves the community as an active participant in the research, as opposed to studies which fail to recognize community involvement as a legitimate and important step in the research process.

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Issues in Hispanic Alcohol Prevention Research: Comments from a Clinical-Community Orientation

Judith A. Arroyo

Introduction

This paper will first comment on controversies about the shortage of prevention research in ethnic and racial communities raised during the proceedings of the "Working group on alcohol prevention research in ethnic communities" from the perspective of a clinically trained, community-oriented academician. The ideas expressed in this paper are synthesized from a variety of sources: (1) the other papers delivered at the working group and published in this volume, (2) the greater Hispanic alcohol literature, (3) the community psychology and ethnic/racial mental health literatures, (4) the comments of the working group participants, and (5) the experiences and thoughts of the author

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about conducting research on the influence of acculturation on Hispanic use of alcohol and the prevention thereof. It will provide a framework to conceptualize the various approaches to psychosocial research in ethnically and racially diverse communities and discuss their relevance to the obstacles the working group noted to conducting prevention research in the Hispanic population. Finally, it will argue that a model of acculturation, one that posits that adaptation to the Hispanic and Anglo cultures are independent of each other, might shed light on alcohol-related risk and resiliency factors in the Hispanic population.

Members of the working group commented on the apparent paucity of research focused on the prevention of Hispanic alcohol abuse. One recent review (Ames and Mora, 1988) found only one published study and eight unpublished ones. Since prevention programs are operating in the Hispanic community, why are reports so rare? The working group identified numerous contributing factors: (1) The pressing need for treatment in the Hispanic community may overshadow reports on prevention efforts; (2) obstacles to obtaining funding for, conducting rigorous evaluation of, and publishing the results of prevention programs are too great for grassroots organizations; (3) the shortage of culturally competent researchers; and (4) communities of color are highly suspicious of academic researchers and make access to subjects difficult for researchers.

While leaders of the Hispanic community are interested in preventing alcohol-related problems, the need for treatment often takes precedence over prevention. When prevention efforts are undertaken at a community level, program staff is often not conversant in nor condoning of the sophisticated techniques necessary for rigorous evaluation (i.e., design and statistics, random assignment, no intervention controls, etc.). Finally, anyone who has attempted to apply for funds without a credible list of scholarly publications in the area can attest to the obstacles in competing for grants. For some, it might appear that they cannot get a grant without publications but cannot get the publications without the data generated from grants.

Many participants in the working group felt that the lack of prevention research was related to the critical shortage of

culturally competent researchers from either the Hispanic or non-Hispanic cultures. Training large numbers of Hispanics as a solution to the scarcity of prevention research assumes they will all apply their advanced degrees both in their communities of origin and by undertaking prevention research. Hispanics with post-graduate degrees are in high demand. Prevention research has to compete with careers in teaching, treatment, community action, and business. The working group endorsed the need to identify, mentor, and graduate interested Hispanics and other persons of color to promote research in communities of color. Yet, we generally agreed that this could not and should not be the ultimate solution to the shortage of culturally competent prevention research. Relying solely on Hispanics to conduct prevention research would contribute to the sentiments expressed by the working group that community-based research is restricted to people of color and contribute to hesitation by non-Hispanic Whites to engage in such work.

Instead of relinquishing responsibility for conducting prevention research to those whose ethnicity matches that of the target community, we need to focus on training **all** researchers to be competent to conduct culturally sensitive work in diverse populations. The American Psychological Association's *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (1990) could serve as a model for developing a similar set of research guidelines. As Moran (1992) noted, cultural competence can become part of the basic training of researchers in graduate programs. Unfortunately, there are few graduate programs that are mandating cultural competence training as part of the core curriculum (Porsche-Burke, 1991).

History of Research with Diverse Populations

The working group debated what constitutes culturally competent research and the relationship this may or should have to the obstacles investigators face when conducting research in communities of color. There has been considerable attention in both the minority mental health and community psychology

literatures to the shortcomings and strengths of research with diverse populations. A brief review of this history may explain why there is so much resistance by culturally and racially diverse communities to allow further research to be conducted.

Failure to Address Cultural Diversity

One of the most basic research errors is to fail to take ethnic or racial background into account when results are to be applied to culturally diverse groups. Caetano (1990) concluded that, while empirically rigorous survey research conducted in the 1960s expanded our general understanding of alcohol use, few Hispanics were included and they were never the focus of analyses. "No detailed descriptions nor major conceptual models regarding drinking by members of this ethnic group were developed." (p. 1231). Similarly, Gilbert (1992) noted the multitude of "white only or White dominated" school-based prevention programs. Thus, a major limitation of alcohol prevention and treatment research has been that too much of the empirical work has focused on non-Hispanic Whites, treating the problem as a generic concept devoid of cultural context (Caste, 1981). When researchers or research consumers are not experienced with cultural variation, they tend to interpret results of work conducted with non-Hispanic Whites equally across ethnic groups.

A related research flaw is the failure to report or directly address the ethnic/racial composition of samples. It is all too easy to neglect ethnic variability with Hispanics by describing subjects as "Caucasian" because they are technically members of this racial category. Such reporting obscures critical information that influences design, measurement, interpretation, and application of the research. Interactions with colleagues who are ill at ease when they do not match their population's ethnic/racial background or who ignore differences across ethnic groups suggest that they do not feel "culturally competent" to address issues of diversity. This highlights the problem of relying exclusively on persons of color to address the growing need for data on diverse populations.

Models of Psychosocial Research with Diverse Populations

Other types of issues arise when ethnicity or race is incorporated into research. These are particularly relevant to the difficulties investigators have in gaining access to communities of color. Sue, Ito, and Bradshaw (1982) discuss three orientations to psychological research with diverse populations: (1) inferiority, (2) deficit, and (3) bicultural or multi-cultural models. The first two demonstrate the tendency to make pejorative comparisons between people of color and a "standard" or control group. This practice is particularly biased when the current standard in much of psychological theory, measurement, and methodology is a White, middle-class, educated, youthful population (see Sears, 1986). This is especially so when clinical research has demonstrated that psychologists' standard for psychological health and well-being is male as opposed to female (Broverman, et al., 1970), and Anglo American as opposed to Mexican American (Lopez, 1977).

Cultural Inferiority Model. The inferiority model of cross-cultural research is predicated on comparing a diverse group to a "normative" standard. Psychosocial models developed for Western, first world, White, usually affluent groups are tested among groups that do not fit this description. The generalizability of psychological theories and research methods to diverse cultures has come into serious question (Benacourt and Lopez, 1993; Pepitone and Triandis, 1987). In light of our knowledge of the culturally biased and/or specific nature of most assessment tools, it is not surprising that diverse groups frequently score lower on the dimension of interest. What is particularly disturbing about this style of research is the interpretation of results so that the diverse group is judged to be inferior to the non-Hispanic White standard. Inferences have strayed so far as to imply that genetic inferiority accounts for results. A classic example of such a biased interpretation in the alcohol literature is the Fenna, et al. (1971) study which came to the controversial conclusion that Native Americans metabolized alcohol at a significantly slower rate than did non-Hispanic Whites. While these results have

since then been attributed to methodological flaws, researchers continue to seek biological weakness in people of color. Recently, there has been an effort to find differences between Hispanics and Whites on possible biomarkers for excessive alcohol consumption (LaGrange, et al., 1993). While such research may provide useful information, the risk of interpreting results as indicative of biological inferiority is great.

Cultural Deficiency Model. Cultural deficiency model research still compares diverse groups to non-Hispanic Whites. However, according to this model, any differences found are not attributed to some biological/genetic flaw but to social and cultural factors. Communities of color are seen as suffering the effects of societal prejudice and discrimination. Perhaps the most memorable research examples are found in the "culture of poverty" research of the 1960s, such as *Tally's Corner* (Liebow, 1967) and *The Children of Sanchez* (Lewis, 1961). Cultural deficiency interpretations might sound less derogatory than inferiority explanations; however, this may not be so for people of color who feel shamed when research reports reinforce cultural deficiency stereotypes (Moran, 1992). While no longer thought to be biologically inferior, they find themselves doomed to live in a culture that is likely to damage their psychosocial development or well-being. The emphasis in the cultural deficiency model is on weaknesses over strengths, competencies, and adaptive skills found within communities of color.

The manner in which "machismo" is used to account for heavy, frequent drinking among Hispanic males often takes on cultural deficiency overtones. This is especially so when a culturally sanctioned concept about appropriate male behavior is taken out of context, exaggerated, and used in an ethnocentric, stereotypical fashion. Machismo and its relationship to alcohol problems is seldom operationally defined and measured (Alcocer, 1982; Caetano, 1990). The degree to which research finds that culturally defined gender roles and male prerogatives relate to alcohol problems may depend on the way in which terms like "macho" or "real men" are employed therein. Machismo has been defined as the culturally sanctioned manner in which a man expresses male or family pride, discipline, authoritarianism,

and dominance (Falicov, 1982). However, its usage has degenerated in the vernacular to a stereotypical exaggeration of male aggressiveness, masculinity, sexism, etc., which is commonly used to describe non-Hispanic as well as Hispanic males (e.g., a real macho man). Thus, it is unclear what aspect of the male role subjects are referring to when they endorse items like "A real man can hold his liquor". (Caetano, 1990, p. 1233).

Communities of color have had considerable experience with cultural inferiority and deficiency model research. This has led to a general distrust of researchers and impediments to their gaining access to subjects in diverse communities. Why should leaders help investigators whom they suspect might engage in exploitative research? Community leaders are hesitant to encourage their constituents to give honestly and generously of their time to researchers who might behave in an opportunistic or cavalier fashion. Increasingly, community leaders are demanding a reciprocal partnership with the research team. Cervantes and Garcia (1992) and others in this volume (e.g., Beauvais, Moran, Gilbert, or Stubben) provide suggestions as to how to develop such a collaboration. Furthermore, leaders are demanding clear promises that the researchers will donate something of value in return for endorsing investigations. The working group discussed several examples of such payback: (1) hiring locals to staff programs, (2) renting offices within the target community, (3) mentoring aspiring researchers, (4) paying subjects and/or institutions for participation, (5) educating community members about the target problems and research, (6) reporting results back to the community in an understandable and usable fashion, and (7) leaving equipment (e.g., computers, audio and video equipment) in community schools or centers, etc. Granting agencies will need to work out mechanisms for addressing these issues.

Bi/Multi-cultural Model. Sue, et al. (1982) proposed a bi/multi-cultural approach that emphasized an understanding of the diverse group in their own terms. Whereas the previously discussed models highlight similarities and differences between groups, bi/multi-cultural research explores the dynamic interplay and interaction between diverse and United States Western-

based values. At times this may entail comparing Hispanics to non-Hispanic Whites when such contrasts are demanded by the hypotheses being tested or have valuable treatment or prevention implications. For example, Caetano (1992) points out that while Hispanic women are much more likely to abstain from alcohol than non-Hispanic Whites (46% v. 36%), frequent heavy drinkers are older among Hispanic than among non-Hispanic White women (50's v. 30's). However, the research community should come to realize that not all investigation demands comparison to some hypothetical normative standard.

Alternative Perspectives on Alcohol Prevention Research EMIC Models

There are other alternatives to imposing theory, design, and measurement developed for White populations onto communities of color. Raising the etic-emic distinction made in cross-cultural psychology is appropriate at this juncture (see Brislen, 1993). The term *etic* applies to concepts and theories that are common across cultures. Much of psychological research and practice currently assumes that concepts rooted in Western, first world societies are etic and valid for diverse cultures. The alternative is an *emic* viewpoint that seeks to understand culture-specific concepts. Emic research investigates how aspects of a culture influence behavior. Emic and bi/multi-cultural research are similar except that emic research avoids comparisons, whether implicit or explicit, with other groups. As far as an emic-oriented researcher can investigate from within that culture's perspective, it is possible to avoid imposing the biases associated with the culture of science (Beauvais, 1992). In contrast to the pejorative contrasts often set up in comparative work, emic research allows for exploration of how a culture might promote healthy behavior in its members. Alcohol prevention work has much to gain from research that can discover how culturally related variables contribute to both the vulnerability and the resilience of Hispanics.

Viewing the concept of macho solely from the perspective of the Mexican or Mexican American culture allows us to inte-

grate rich ethnographic material not often cited in this context. An emic researcher might discover that the original cultural ideal of being "muy macho" or being a "real man" includes fulfilling responsibilities and obligations to his family, protecting and defending his family's interest, and serving as a good role model to his children (Panitz, et al., 1983). Rodriguez-Andrew, et al. (1988) found that Hispanic male "Access to and participation in drinking activities . . . does not go unaccompanied by a corresponding set of culturally prescribed duties." (p. 117). They cited evidence of the connection between a man's obligations to his family and his prerogative to drink and concluded that sanctioning of male drinking could "stem from cultural concepts of reward and reinforcement for role obligations adequately discharged rather than from traditions of indulgent permissiveness" (p. 118). They speculated that adoption of this attitude may be associated with an increase in women's drinking once they enter the labor force. This may account for the relationship recently found between reporting drinking to reward hard work as a reason for drinking and heavy and frequent drinking for both Mexican American men and women (Golding, et al., 1992).

Hispanic Heterogeneity

How might research on Hispanics that does not compare them to non-Hispanic Whites promote effective prevention? An attempt to organize our knowledge of the relationship of acculturation and gender roles to Hispanic drinking patterns will provide excellent examples of how to improve the state of the art in prevention research. First, such an orientation would force one to integrate the tremendous heterogeneity of the many cultural groups encompassed within the generic Hispanic label. Even the criterion employed to define an Hispanic group (e.g., national group, origin of ancestors, family of origin, or birthplace) has impact on findings (Caetano, 1986). Hispanic females from different national origins evidence variability in drinking patterns (Caetano, 1988a; Gilbert and Cervantes, 1986). Although rates of abstention and infrequent drinking are similar for Mexi-

can and Puerto Rican females (69% v. 62%), their rates of frequent high maximum and of frequent heavy drinking are very different (14% v. 5%) (Caetano, 1987).

Regional, class, age, education and acculturation differences make it impossible to generalize even within a national origin group. There are regional differences in patterns of Mexican American alcohol use in Texas and California (Caetano, 1988b). While rates of female abstention are very similar, Mexican American females in Texas have a higher rate of infrequent drinking than in California (29% v. 8%). Likewise, Californian Chicanos have higher rates of frequent high maximum and frequent heavy drinking than their Texan counterparts (19% v. 4%). Emphasizing a thorough understanding of the target group over comparisons with non-Hispanic Whites would have considerable impact on improving prevention intervention and evaluation.

Acculturation and Acculturative Stress

Acculturation and the stresses associated with it have been implicated in Hispanic drinking (Gilbert and Cervantes, 1986). Acculturation is a process that entails changes in culturally patterned values, beliefs, attitudes and behaviors that transpire when two cultural groups come in close contact. Gilbert (1991) noted several important trends in her recent analysis of acculturation and alcohol use among Mexican American women. Mexican American females are very likely to be abstainers or very light drinkers. While they do not alter their pattern of abstinence or low frequency, low quantity drinking upon immigration, they show a linear change in drinking pattern across generations in the U.S. By the third generation they are drinking more like American than Mexican women. This suggests that perhaps some aspects of the traditional Mexican culture lower risk for alcohol-related problems among females and that either loss of these factors or increased interaction with the dominant culture increases risk.

A recent analysis of the relationship between acculturation and mental health status yielded inconclusive results. This was

attributed to problems with the models of and measurement of acculturation and the linkage between these and mental health outcomes (Rogler, et al., 1991). Similarly, Caetano (1990) posits that the parallel failure in the alcohol literature for acculturation to explain differences in alcohol use is due to a lack of sophisticated models of acculturation and its relationship to acculturative stress. He notes that the generally liberalizing effect of acculturation on drinking habits is influenced by sex, age, and birthplace and thus "cannot be seen just in terms of acculturative stresses" (p. 1232). Underlying this conclusion is the unproven assumption that transition from one culture to another is inherently stressful, and that acculturation and acculturative stress are linearly related (Beauvais, 1992; Oetting and Beauvais, 1990). While early descriptions of the relation of Hispanic acculturative stress to alcohol use failed to define the concept clearly (Gilbert and Cervantes, 1986), more recent work has empirically investigated the stresses Hispanics encounter when acculturating to U.S. society (Cervantes, et al., 1990). One cannot assume that acculturative stress invariably accompanies an increase in the level of acculturation. Not all ethnic groups in the U.S. experienced incapacitating stress in the process of assimilating into the majority group.

Limitations of Current Models and Measures of Acculturation

Theories and accompanying measures of Hispanic acculturation are under considerable investigation, especially among Mexican Americans (Keefe and Padilla, 1987). These have included crude proxies for the concept such as language usage, birthplace, or number of generations in the United States as well as more refined measures such as uni-dimensional and multidimensional bipolar linear scales, semantic differentials, typologies, and two-culture matrix models. Organizing our knowledge of the influence of acculturation on alcohol use patterns within a framework of the interaction between the United States and Hispanic cultures might help account for paradoxes in the Hispanic alcohol

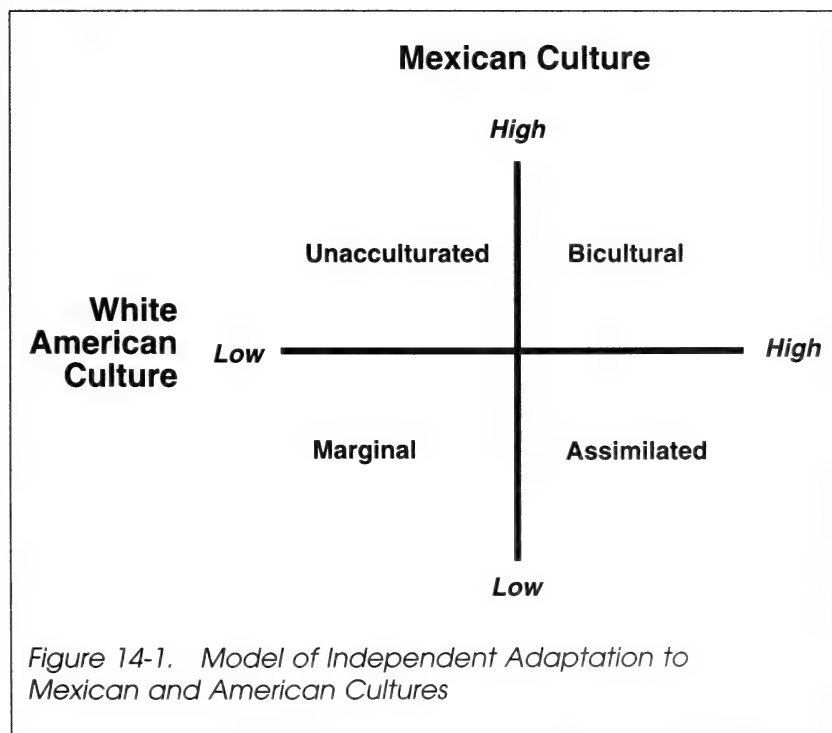
literature. That is, perhaps there are ways to conceive of acculturation that can account for many acculturative options and still be consistent with the evidence about the influence of other factors such as sex, age, education, income, and birthplace on alcohol use.

Caetano (1990) argued that we need to consider more complex models of acculturation such as Berry's (1990) ideas, which allow not only for stress and marginality but for integration and assimilation. Similar suggestions have been made in the Hispanic mental health literature. Rogler, et al. (1991) concluded that the dominant bipolar linear models of measuring acculturation constrain a subject's responses to mutually exclusive, competitive choices between Hispanicism versus Americanism. They join others in arguing "for the need for separate measure of . . . cultural involvement" (Rogler, et al., 1991, p. 587). In the alcohol literature, Beauvais and colleagues (Beauvais, 1992; Oetting and Beauvais, 1990) have posited an orthogonal model of acculturation by which adherence to ethnic or traditional cultures (i.e., Hispanic and Native American) can vary independently of subscribing to the dominant non-Hispanic White culture. One can integrate these ideas into a framework that shows promise to be a sophisticated model of acculturation that is consistent with the results of research on patterns of Hispanic alcohol use.

Berry (1990) conceptualized acculturation as a function of the responses an individual makes to two questions: (1) To what degree do I want to retain my culture of origin? and (2) To what degree do I want to interact with members of the society other than my own group? Oetting and Beauvais (1990) presented their subjects with a conceptually related set of questions: "(1) Do you live in the . . . way of life? (2) Will you be a success in the . . . way of life?" Subjects are asked to evaluate their involvement and success in their traditional culture (e.g., Spanish/Mexican American or American Indian) and the White American society. Integrating these two perspectives yields a model of acculturation that hypothesizes that successful adaptation to the Mexican and Anglo American cultures vary independently of each other.

Model of Independent Adaptation to Mexican and American Cultures

According to the proposed model of independent adaptation to Mexican and American cultures, individual or group acculturation would be plotted in one of four quadrants as a function of quantitative assessment of degree of adherence to each culture. The four quadrants (see figure 14-1) created by the intersection of the two cultural axes are similar to the varieties of acculturation proposed by Berry (1990) but are relabeled with terms more commonly employed by Hispanic scholars to describe the acculturative process (e.g., Keefe and Padilla, 1987; Mendoza and Martinez, 1981; Olmedo, 1980). For example, high adaptation to the Mexican culture accompanied by high adaptation to the



American society describes the variety of acculturation that Berry (1990) would call integration but Chicano scholars would term bicultural. Berry would have called low adaptation to the American culture in combination with high adaptation to the Mexican culture separation, whereas the present model employs the more commonly used term *unacculturated*.

This model of acculturation can provide a different perspective on the relation of concepts such as anomie and acculturative stress to alcohol use. It has been suggested that anomie, or alienation from society, cannot account for Hispanic women's drinking patterns because their increased use of alcohol is associated with higher levels of education, income, working outside the home, and being U.S.-born (Caetano, 1990). Johnson and Matre (1978) failed to find that anomie predicted Mexican American drinking, and concluded that the concept was "an 'Anglo' concept that should not be applied to a person of another culture without adapting the concept to that culture" (p. 901). The new model allows for a different interpretation of these results. Johnson and Matre (1978) suggested that an acculturated Mexican American woman's use of alcohol might not imply alienation from the Anglo American culture but the "degree to which she is alienated from *her* culture" (p. 901, emphasis added). Similarly, perhaps the educated Mexican American woman who works outside the household and drinks in a wide range of social settings may be experiencing stress related not so much to being out of harmony with non-Hispanic White norms but with Mexican cultural ideals about appropriate behavior for a woman.

The lead article in a recent issue of *Hispanic* magazine (Anders, 1993) highlighted the conflicts that working Hispanic women experience when emerging from a culture that "encases the woman in the role of self-sacrificing mother and homemaker" (p. 14). One managerial-level working mother reported, "When I see a mom with a kid, it makes me feel bad because it's like I'm supposed to be doing that-because I've been raised that way" (p. 14). The article went on to report on the research of psychologist Lillian Comas-Díaz that found Hispanic women were experiencing pressure to be "superwomen" vis-à-vis both work and family requirements. She concluded, "because you

don't want to be fired from either job. That creates an added stress" (p. 18).

While becoming better educated and working outside the household may show adaptation to the non-Hispanic White way of life, it may also imply alienation from the Mexican culture in terms of gender-appropriate roles. Gilbert (1985) noted that Mexican American women's drinking is limited to private settings with family and close friends. A woman who drinks in other settings may have decreased her adherence to the Mexican culture. Thus, an educated woman who works outside the household and drinks in a variety of public settings might fall into the assimilated quadrant. In contrast, a Hispanic woman who expands her roles to include activities outside the household but retains cultural prohibitions about drinking would likely be in the bicultural quadrant. This perspective on the balance between Hispanic women's advancement in the American way of life and the degree of adherence to the Mexican culture has considerable implications for alcohol prevention and treatment. Education/prevention programs could warn Hispanic women of the stresses associated with becoming successful in the non-Hispanic White way of life and/or the more liberal attitudes about women's use of alcohol in the dominant culture. Prevention and/or treatment could focus on retaining Hispanic cultural limitations on female drinking and/or suggest other options for coping with stress. Prevention messages aimed at the upwardly mobile Hispanic woman would, in effect, encourage movement from the unacculturated into the bicultural quadrant.

Another example might help to bolster the proposition that adherence to traditional Hispanic cultural norms may be healthy for women, albeit perhaps not necessarily for men. Mexican immigrants have considerably less access to family and extended family ($M = 5$ relatives) than do their second and third generation U.S.-born counterparts ($M = 17$ and 15 respectively) (Keefe, et al., 1978). This loss of familial support may influence Hispanic male and female drinking quite differently. Recently immigrated men are known to alter their drinking patterns from one of less frequent, high quantity drinking in Mexico to frequent, high quantity usage within five years of immigration (Caetano and

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Assessment of Adaptation to Mexican and American Cultures

The Mexican and American cultural model outlined above shows promise to address concerns in both the Hispanic mental health and Hispanic alcohol literatures. Unfortunately, development of

the theoretical underpinnings of the model has outdistanced evolution of accompanying measurement instruments. While many components of the requisite independent Mexican and American adaptation scales are clearly indicated by present consensus about variables influencing acculturation, the truly comprehensive measurement of "Americanness" is very complex. Various different approaches have confirmed basic factors known to influence acculturation such as language familiarity, usage, and preference; generational status and ethnic identification; cultural exposure; and, social interactions (e.g., Cuellar, Harris, and Jasso, 1980). Items from existing linear bi-polar scales may be easily adapted to assess level of adaptation to the Hispanic and American cultures independently.

For example, linear models of acculturation are associated with items that ask if one speaks, reads, or writes better in English versus Spanish. Theory underlying the present model would dictate that inquiry be made about the two different cultures separately from each other. Thus, items should solicit degree of competence in the various components of each language—for example, "How well do you speak English?" and "How well do you write Spanish?" This allows for more comprehensive assessment of proficiency in both languages. A subject who indicates s/he reads or writes better in Spanish than in English may still be functionally illiterate in both. Where appropriate, knowledge of the limited reading and writing ability of a target population could save wasted efforts on producing prevention literature and dictate a focus on oral sources to disseminate prevention messages. This new approach to assessing acculturation adds a new dimension to the information available about subjects who would indicate they were equally adapted to the Mexican and American cultures. The **quality** of adaptation, i.e., equally adept and skilled or equally inept and unskilled, determines placement in either the bicultural or marginal quadrant. A highly bicultural individual may well require different prevention and treatment intervention than a truly marginal person.

Limitations of Measurement. There are aspects of successful adherence to the Mexican culture, such as the manner in which familism and religiosity are expressed (Cervantes and

Garcia, 1992), which do not have a clear and straightforward analogue in the non-Hispanic White way of life. Attempts to determine what values, behaviors, and beliefs connote successful adherence to the non-Hispanic White way of life have proven difficult. One is trying, in effect, to measure "generic American-ness" in a society that is extraordinarily multi-ethnic in composition. However, there is evidence that subjects can report on the degree to which they adhere to and anticipate being successful in the White American way of life (Oetting and Beauvais, 1990). Presently, research is under way to determine what constitutes living by and being successful in the Mexican American/Hispanic and non-Hispanic White ways of life. This will, hopefully, advance and refine efforts to measure independent adaptation to the Mexican and American cultures.

Conclusion

While epidemiological information about Hispanic alcohol use has expanded tremendously in the past two decades (see Caetano, 1987, 1988a, 1988b; Gilbert 1988), this knowledge has not served to significantly advance efforts at primary or secondary prevention of Hispanic alcohol abuse. The present paper briefly explored some factors that are related to the lack of progress in alcohol prevention. The effects of past insensitivity to the impact of ethnic and racial diversity on alcohol-related problems and the failure of the culture of science to treat communities of color with respect have contributed to community leaders' resisting further research. The argument was made that reciprocal partnerships between communities of color and investigators are necessary to overcome a long and negative history between the two. Various ways of engaging the Hispanic community into the process of facilitating prevention research were suggested.

Investigators must become culturally competent to overcome a community's suspiciousness of research and hesitancy to engage in the research process. An investigator's basic orientation to the integration of cultural variables into prevention research is differentially likely to alienate or engage the Hispanic community. While some comparison of Hispanic to non-His-

panic White patterns of alcohol use can be helpful to improve prevention efforts, shifting paradigms to examine Hispanic alcohol use exclusively shows promise to increase our knowledge of vulnerability and resiliency factors. Also, viewing acculturation as a process of independent adaptation to Hispanic and American culture might help to better integrate and apply present results and further prevention of alcohol-related problems.

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Alcohol Abuse Prevention Research in African American Communities

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Introduction

Alcohol affects virtually every organ and tissue in the body deleteriously and is indirectly if not directly responsible for almost 100,000 deaths annually (United States Department of Health and Human Services [USDHHS], 1990, 1987). Besides the loss of many lives, it is estimated that alcohol abuse costs Americans more than \$135 billion annually in lost employment, reduced productivity, and health care for alcohol-related conditions such as alcoholism, cirrhosis of the liver, and various forms of cancer (Hammond, 1991). Clearly, the toll that alcohol abuse exacts upon all Americans is tremendous, but, given high rates of poverty, chronic unemployment, and the lack of quality health care, the impact of alcohol upon African Americans is particularly pernicious. In fact, some have characterized alcohol abuse as the number one mental and social problem of Black Americans (Bourne, 1973; Harper, 1976; Watts and Wright, 1983).

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After key demographic and social characteristics of the African American population are reviewed, this paper examines the prevalence and patterns of alcohol use among African Americans, the norms associated with their use of alcohol, the impact of alcohol abuse on their health and well-being, methodological issues and concerns in the study of their use and abuse of alcohol, the relationship between the alcohol industry and African Americans, and, finally, issues related to the prevention of alcohol abuse and alcohol-related problems among African Americans.

The African American Population

There are at least 31 million Americans of African descent in the United States, constituting more than 12 percent of the total population. Although most of them trace their roots to West Africa, African Americans are in reality a heterogeneous group, of Afro-Caribbean, Afro-Latin, Afro-Indian, Afro-European, and other descents. Accordingly, any effort to characterize the behavior of the "African American community" or "Black community" is difficult if not impossible. Nevertheless, without data that examines cultural and ethnic differences in the meanings, prevalence, and patterns of alcohol use within the "Black" population, the present discussion focuses on the aggregate—all of those persons who define themselves, or who are socially defined, as "Black" or "African American."

In addition to the racial and ethnic diversity within America's Black population, there is also considerable diversity in its socio-demographic characteristics. Some of these characteristics may place African Americans at greater than average risk for alcohol abuse, while others may act as protective factors against the abuse of alcohol. For example, although there is a broad age spectrum among African Americans, the population is relatively young, with more than 60% being under age 35 and a median age of 28 years (U.S. Census, 1992). This youthfulness, coupled with many Black people's ambivalence regarding the use of alcohol, makes them prime targets for early prevention efforts. On the other hand, this youthfulness may make them especially vulnerable to experimentation with alcohol, family problems

related to the alcohol abuse, interpersonal violence, crime, and other difficulties associated with youthfulness and related to alcohol abuse.

Beyond being relatively young, a sizable number of African American families (29 percent) are poor, with poverty being concentrated among children and single female parents (U.S. Census, 1992). Poverty, linked with the stress associated with being a single parent, may place many Black women and their children at increased risk for alcohol abuse and alcohol-related problems. A strong correlate, if not cause, of poverty and female-headed families is unemployment, particularly among males. The annual average labor force participation rate among Black men in 1991 was 70 percent (U.S. Census, 1992). High rates of unemployment, underemployment, and the subsequent inability to fulfill their role as economic providers may cause many Black men to experience increased psychological strain, thus placing them at high risk to abuse alcohol and other drugs.

Linked to poverty, unemployment, and persistent institutional racism is the continued existence of residential segregation. As at least a partial consequence of residential segregation, more than half the Black population lives in the nation's central cities (U.S. Census, 1992). Because of their heavy concentration in inner cities, African Americans are exposed, disproportionately, to many liquor stores, bars, billboards, and other alcohol advertisements, all factors that place them at increased risk for alcohol abuse (Hacker, Collins, and Jacobson, 1987; Moskowitz, 1989).

A major "protective factor" against alcohol abuse to which many Black people are exposed is religion. Related to their southern heritage, many African Americans claim ties to Baptist and other fundamentalist religious denominations, many of which have strong abstinence beliefs and traditions (Herd, 1989). Abstinence norms established at the denominational level and the congregational level, social involvement with other church members who abstain or drink very little, and individual beliefs that alcohol abuse is a violation of God's laws (i.e., sin), are clear ways in which church involvement can serve to reduce alcohol abuse.

During the last 30 years there has been a growing segment of upwardly mobile African Americans who, through various

educational and other opportunities, have joined America's social and economic mainstream. On the other hand, there persists to be many disadvantaged Black people who experience poverty, unemployment, single parent families, residential segregation, continuous exposure to pro alcohol messages, and no religious affiliation. This "high risk" group is often the focus of media reports and scientific research, while the lifestyles and patterns of behavior found in the general African American population are often unexplored. In the next section a broader perspective is taken to examine the norms, patterns, and prevalence of alcohol use and abuse among African Americans.

Alcohol and African Americans

The most recent Secretary of Health and Human Services Report on Alcohol (USDHHS, 1990a) correctly notes that "alcohol research has only recently begun to focus on racial and ethnic minorities" (p. 32). Alcohol abuse has long been assumed to be a problem among African Americans, but until recently very little research examined this assumption empirically. An early literature search of over 16,000 alcohol-related studies reported in scientific journals between 1939 and 1974 yielded only 77 articles that discussed findings related to Black people (Harper and Dawkins, 1976). Since the mid-1970s there has been an increase in the research on African Americans' alcohol use and a concomitant growth in knowledge about this important topic. Despite the increase in research on the use of alcohol among African Americans, however, empirical evidence drawn from different sources yields information that both confirms and contradicts the assumption that there is a great amount of alcohol abuse among Black people in America. For example, survey research indicates that Black Americans drink less, on average, than do other groups and that they are more likely than others to abstain from any use of alcoholic beverages (Herd, 1989). On the other hand, survey data also suggest that Black people who do drink are more likely than average to experience alcohol-related problems (Herd, 1991). These issues are examined more closely below.

Prevalence and Patterns

The extant research shows that there are significant within and between race differences in the prevalence of alcohol use and in the relationship between alcohol use and several important demographic characteristics including gender, age, income, and location of residence (Herd, 1991).

Gender. Alcohol use among Black males exceeds that of Black females, among both young people and older adults (Bachman, et al., 1991; Herd, 1989). For example, Bachman, et al. (1991) report that 49% of Black male high school seniors used alcohol in the last 30 days compared to only 33% of Black females. Similarly, male seniors (24 percent) were almost three times as likely as female seniors (9 percent) to be binge drinkers (i.e., five or more drinks, in a row, within the last two weeks). Findings from the 1984 National Alcohol Survey (Herd, 1991) are consistent with those from seniors. Nearly half the Black women (46 percent) reported that they abstained from alcohol use compared to only 29 percent of Black males, and only 4 percent of the women were frequent heavy drinkers compared to 15 percent of the men.

Turning to race differences, in the National Alcohol Survey the drinking patterns of Black and White men were similar, but Black men were slightly more likely to abstain (29 percent versus 24 percent) and slightly less likely to be heavy drinkers (15 percent versus 19 percent). Among females, roughly equal proportions were heavy drinkers (i.e., 4 percent of Black women and 5 percent of White women), but Black women were much more likely than White women to abstain (46 percent versus 34 percent) (Herd, 1991).

Age. Existing evidence suggests that there are important age-related differences in the patterns of alcohol use among Black people and between Black people and White people. Table 15-1 presents recent findings from national samples of Black and White 8th, 10th, and 12th graders. The data indicate that, on average, alcohol use increases with age among Black students. An interesting exception to this general rule is the slightly lower prevalence of heavy drinking (i.e., 5 or more drinks in a single

Table 15-1: Lifetime, Annual, Thirty-Day, and Heavy Recent (5 or more drinks in a single sitting in the last two weeks) Alcohol Use, by Race and Grade Level

Grade	Lifetime		Annual		Thirty-Day		5 + Drinks	
	White	Black	White	Black	White	Black	White	Black
8th	71.8	64.5	56.0	43.6	26.0	17.8	12.6	9.9
10th	85.6	78.5	75.4	60.8	45.7	30.2	24.4	14.4
12th	89.8	80.3	80.5	64.3	57.7	34.4	32.9	11.8

Source: Johnston, L.D., O'Malley, P.M. and Bachman, J.G. *Smoking, Drinking, and Illicit Drug Use Among American Secondary School Students, College Students, and Young Adults*. Vol. 1, Table 10, Rockville: USDHHS, 1992.

sitting) among 12th graders relative to 10th graders. While it is possible that this finding occurred by chance, it is also possible that Black youth who drink heavily do not stay in school until their senior year, and thus they are not in the sample of seniors.

Concerning race differences, the table shows that Black students are less likely than White students to have ever used alcohol, to have used alcohol in the past year, to be current drinkers, or to drink heavily. It should be noted that the magnitude of the race differences in use is largest among seniors; however, some of this difference may be the result of the slightly higher national dropout levels among Black students compared with White students. Data from the 1991 National Household Survey (National Institute on Drug Abuse, 1992) is consistent with the student findings: Black people in each age category are less likely than their White counterparts to drink (see Table 15-2). It should be noted, however, that the age-related prevalence differs by

Table 15-2. Lifetime, Annual, Thirty-Day Alcohol Use, by Race and Age

Age	Lifetime		Annual		Thirty-Day	
	White	Black	White	Black	White	Black
18-25	93.2	82.5	86.8	72.8	67.2	56.0
26-34	94.4	88.6	83.7	72.7	63.8	57.1
35+	88.7	84.3	66.2	56.6	50.9	40.3

Source: National Institute on Drug Abuse (NIDA), National Household Survey on Drug Abuse: Population Estimates 1991 (Revised November 20, 1991, Tables 13-B and 13-D. Rockville: USDHHS, 1992.

race. Among the White respondents, use is highest among the youngest age group (18–25) but declines thereafter. Among Black respondents, however, there is no difference in the level of use among the youngest respondents and those in the middle group. The decline in use among Black respondents does not begin until after age 35.

Income. Past research, conducted on predominantly White samples, indicates that alcohol use is typically highest among those with high incomes (Herd, 1991). In contrast, among Black people, the prevalence of heavy alcohol use is highest among moderate income males and females and lowest among those in the highest income category (i.e., \$30,000 and over) (Herd, 1991). Among White respondents, heavy use was highest among males in the highest income category and among females in the moderate income categories.

Not surprisingly, research that has explored alcohol use in low income areas (e.g., housing projects) has found higher rates of heavy drinking among Black respondents than those reported in national samples (Herd, 1989). This finding suggests that alcohol abuse and alcohol-related problems, like most social problems, are disproportionately located among those who are poor.

Region and Urbanicity. The region of the country and the size of the city in which one lives is related to the prevalence and level of alcohol use (USDHHS, 1990). Nationally, for Black men, abstinence is highest in the Northeast (34 percent) and the South (34 percent) and lowest in the North Central (17 percent) and Western regions (20 percent) (Herd, 1991). Frequent heavy use among men is lowest in the North Central region (12 percent) and only slightly higher in the Northeast, South, and West (16 percent, 15 percent, and 15 percent, respectively). The size of the community has relatively little impact on the level of abstinence among Black men. On the other hand, heavy drinking is twice as prevalent in large metropolitan areas (20 percent) as in smaller metropolitan (10 percent) areas and non-metropolitan areas (10 percent). Among Black women, abstinence is highest in the South (56 percent), lowest in the North Central region (31 percent), and intermediate in the Northeast (34 percent) and the West (34 percent) (Herd, 1991). The prevalence of frequent heavy drinking

among Black women is low across regions, with it being the highest in the West (7 percent), followed by the North Central (6 percent), the South (4 percent) and the Northeast (3 percent). Community size also significantly relates to abstinence among Black women. Abstinence is highest in non-metropolitan areas (59 percent) and roughly the same in large and medium-sized metropolitan areas (42 percent and 41 percent, respectively). The prevalence of heavy drinking is not significantly different in large metropolitan areas (5 percent), medium metropolitan areas (4 percent) and non-metropolitan areas (4 percent).

Despite evidence from national surveys that Black Americans are more likely to abstain from alcohol use and drink less than Whites, local surveys and ethnographic data suggest that alcohol use and abuse are widely spread problems among African Americans, particularly in urban, high density, low socio-economic areas. Samples drawn from New York state, Boston, New York City, New Haven and St. Louis all found similar levels of heavy drinking among Black men and high levels of abstinence and high levels of heavy drinking among Black women who drink (Herd, 1989).

Norms. Recent survey research and ethnographic studies have given insight into the norms and values associated with alcohol use among African Americans (Herd, 1989). Many African Americans hold ambivalent attitudes toward alcohol. This ambivalence, and the extremes of abstinence and heavy use that characterizes the alcohol consumption patterns of many African Americans, has been called the "two worlds" of Black drinking (Herd, 1989). According to Herd (1989), the first "world," the abstinence norm, is much the result of Blacks' southern, rural, and fundamentalist religious heritage. The second world, heavy use, is associated with the night club culture that developed before and during Prohibition. The night club culture typically centers on bars, taverns, and clubs where alcohol is served regularly and, along with music and dancing, is part of the social atmosphere that characterizes these establishments (Herd, 1989). Beyond use in clubs, bars, and other businesses where alcohol is consumed, most alcohol use among the general Black population occurs on weekends and during holidays, weddings, and other special occasions.

Alcohol Problems and African Americans

For the purposes of the present discussion there are two broad categories of alcohol-related problems: psychosocial problems (e.g., injuries, crashes, crime, interpersonal problems, etc.) and physiological problems (e.g., cirrhosis, throat cancer, and other alcohol-related diseases). The extent to which these various problems impact the African Americans are discussed below.

Psychosocial Problems

Approximately 18 million adults currently experience problems because of alcohol use (USDHHS, 1990). These problems include crime, automobile accidents, impaired job performance, suicide, homicide, and difficulty in personal relationships. Ravenholt (1987) estimates that 30% of the suicides and 50% of the motor vehicle accidents and homicides are related to alcohol use. According to United States Department of Justice (1985) statistics, 54% of the persons convicted for violent crimes used alcohol before they committed their offense. These violent crimes include murder/attempted murder, manslaughter, rape/sexual assault, robbery, and assault. Forty percent of the persons convicted for property crimes (e.g., burglary, auto theft, arson, destruction of property, and larceny) and 64% of the persons committing public order crimes (e.g., weapons possession, obstruction of justice, and driving while intoxicated) had recently used alcohol before their arrest (USDHHS, 1987).

Despite the fact that relatively higher proportions of Black people are incarcerated for various crimes, data from arrest records, prison records and interviews do not support the notion that Blacks who are arrested are more likely to drink heavily than Whites. According to Herd (1989), prison studies show that a smaller proportion of Black than White male offenders were drinking or intoxicated at the time that they committed their crimes.

Although Black Americans do not appear to suffer some of the negative effects of alcohol to as great an extent as Whites for

things such as auto accidents or suicide, data from the National Alcohol Survey suggest that Black men experience a higher level of alcohol-related problems than do White men for every problem except drunk driving (Herd, 1991). The problems that the study examined included financial problems, accidents, binge drinking, loss of control, alcohol withdrawal symptoms, belligerence, job problems, police problems, spouse problems, people problems, and health problems.

Race differences in alcohol-related problems varied by age and income. For White drinkers, problems peaked during late adolescence and early adulthood. Among Black drinkers, however, alcohol-related problems continued to increase until they reached their middle 30s (Herd, 1991). As income increased among Black males the number of alcohol-related problems decreased. For White males, however, alcohol-related problems were highest for those in the highest income category.

Physiological Problems

Numerous physical ills have been associated with alcohol abuse. Alcohol affects the central nervous system, the endocrine system, the reproductive system, and the digestive tract. Alcohol has also been associated with hypertension, pneumonia, influenza, and various cancers including cancer of the lip, mouth, pharynx, larynx, and stomach (USDHHS, 1990).

Epidemiological data show that cirrhosis of the liver is a primary physical consequences of alcohol abuse. Between 1960 and 1970 the cirrhosis mortality rate of the non-White population doubled from about 12 to almost 24 deaths per 100,000 (Herd, 1989). During this ten-year period the cirrhosis deaths for non-White men increased by 276%; for White males the rate increased by 66 percent. The cirrhosis death rate for non-White women increased by 205% while the rate for White women increased by 54% (Herd, in 1989). Since 1973 the cirrhosis rate has declined for all racial groups. Despite this general decline, the cirrhosis mortality rate for Black Americans continues to be disproportionately high. Although the number of cirrhosis deaths has decreased significantly, the ratio of deaths between Whites and non-Whites has remained largely unchanged. Non-Whites still

die at almost twice the rate of Whites (20.0 and 11.1 deaths per 100,000, respectively) (USDHHS, 1987). Hacker, et al. (1987) cite a government study of seven major U.S. cities that found that the cirrhosis mortality rate for non-Whites ages 25–34 was more than ten times the rate for Whites.

Like cirrhosis of the liver, esophageal cancer is also linked to heavy alcohol consumption. Between 1979 and 1981 the rate of esophageal cancer for Black males 35–44 years old was ten times the rate for Whites. The rate for Black women was three to seven times that of White women (Report of the Secretary's Task Force, 1985). Besides higher rates of cirrhosis and esophageal cancer, Blacks also disproportionately suffer other physical consequences of alcohol abuse. These problems include hypertension, obstructive pulmonary diseases, severe malnutrition, and birth defects (USDHHS, 1990).

Methodological Issues and Concerns

Many methodological issues are of concern as they pertain to research on the use and abuse of alcohol among African Americans. These issues include the samples upon which a given piece of research is based, the method of data collection, and potential race and class biases in the reporting of "objective" data.

Important distinctions between local samples and national samples, men and women, youth and adults, regional differences, poor versus middle income, metropolitan versus non-metropolitan, and other distinctions noted above are seldom made in discussions of alcohol use and abuse among African Americans. One reason for the failure to make these distinctions is the over-emphasis most research places on cross-race comparisons (e.g., Black-White differences) than on within-race similarities and differences. Because of this over-emphasis on race comparisons, there is a certain amount of inconsistency and confusion about the actual prevalence and patterns of alcohol use among African Americans and the location (e.g., social class, family structure, urbanicity) of alcohol-related problems.

The race difference emphasis is, perhaps, most problematic when the findings from typically small, non-representative, samples of African Americans (e.g., from treatment centers or housing projects) are extrapolated to represent all African Americans and/or are contrasted with findings from representative samples of White people. A clear distinction needs to be made between research that explores race differences in alcohol use and research that examine alcohol use within the African American population. Put another way, the purpose of the research and the research questions being posed must be clearly articulated, and the limitations and generalizability of the findings acknowledged.

Several methods of data collection are used to gather information on alcohol use and abuse. These methods include the use of surveys and questionnaires, ethnographic studies, and the use of "official" statistics such as death certificates and data from alcohol treatment centers. The sensitive nature of questions about alcohol abuse might increase the likelihood of systematic non-response from African American respondents. Systematic non-response, small, non-random samples, and the fact that school samples and household samples miss those groups most likely to abuse alcohol (e.g., dropouts, the homeless, and incarcerated persons) are all important limitations. Recognizing the limitations of survey research, it should be noted that qualitative methods are no panacea, given their typically small samples, difficulty in replication, and limited generalizability. Aggregate statistics, epidemiological studies, and other "objective" government data are also limited. Aggregate-level data mask individual differences and often only indicate the overall prevalence of various alcohol-related diseases and problems without controlling for such factors as income, education, or regional difference. When these distinctions are not made it is almost impossible to determine, beyond race and gender, what segments of the population are most adversely affected by alcohol.

Even apparently objective data such as that garnered from death certificates is potentially problematic. Because of the difficulty in ascertaining any one problem as the cause of death and the stigma associated with alcohol abuse, doctors may be

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reluctant to identify alcoholism as the primary cause on death certificates. This reluctance may be particularly true when the decedent is White and middle class (USDHHS, 1987). Accordingly, statistics on race differences for alcohol-related causes of death may be distorted; the true number of deaths from alcohol-related causes may be either overestimated for Blacks or underestimated for Whites.

Data from treatment centers may also present an inaccurate picture of race differences in the concentration of alcohol-related problems. According to extant data, African Americans are over-represented in community-based treatment centers. In reality, however, the heavier concentration of African Americans in community-based treatment centers may result from the fact that they lack health insurance and other economic resources that would allow them to seek private treatment.

The existing research has only begun to shed some light on the complex issue of alcohol and the African American community. Multiple data sources as well as multiple data collection and analysis methods are needed to fully understand the patterns, prevalence, norms, and problems associated with alcohol use among African Americans of different ages, genders, socio-economic strata, religious orientations, cultural backgrounds, and geographic locations.

The Alcohol Industry and African Americans

The alcohol industry has a central place in the American economy. In 1990, consumers purchased 86.6 billion dollars in beer, wine, and distilled spirits (Hammond, 1992:5). The industry employs more than 800,000 people and has a payroll of more than \$15 billion (Hammond, 1991:123). Not only is the alcohol industry an important source of jobs, it is also a large source of tax revenues. In 1989, taxes from the sale of wine, beer, and distilled spirits totaled \$13.5 billion (Hammond, 1991:122). It should be kept in mind that the amount of taxes is less than 10 percent of the annual cost of alcohol-related problems of \$136.3 billion (Hammond, 1991:120). Put another way, every dollar of

alcohol tax collected costs Americans \$10.09 in alcohol-related medical costs, lost productivity, crime, and other problems (Hammond, 1991:121).

Targeting African Americans

Although the specific demographic characteristics (e.g., sex, age, education, income) of the African Americans who purchase and consume alcoholic beverages are not well known, we do know that the alcohol industry spends over a billion dollars annually to market its product and that African Americans are targeted disproportionately as consumers (Hacker, et al., 1987; Scott, et al., 1992). The alcohol industry uses the mass media (i.e., television, radio, and print media), outdoor advertising (billboards, posters, etc.), fund-raising events, community service campaigns, and Black advertising firms to promote their products among African Americans. Through advertising, sponsoring activities, and other ventures, alcohol companies provide thousands of jobs and millions of dollars in contracts to minority businesses (Hacker, et al., 1987).

The alcohol industry not only provides jobs and contracts for minority businesses, but also it gets involved in various community activities and efforts to create and sustain a positive image within the community. The list of Black individuals, organizations, and institutions that receive philanthropic funds from the alcohol industry includes Black social, political, and even spiritual leadership (see Hacker, et al., 1987).

The industry hires Black advertising agencies to conduct research and to develop sophisticated Black-oriented advertising programs that use African American language, culture, and role models to sell alcoholic beverages. Alcohol producers also spend a significant amount of money to advertise on Black radio stations, not only to advertise alcoholic beverages but also to inform Black listeners of the various concerts and programs that the industry sponsors. Billboard advertising is yet another medium used to target African Americans. Evidence from various major cities shows that Blacks are disproportionately targeted by billboard ads. A report on the top twenty-five population markets indicates that over 70% of the ad money spent for the eight-

sheet billboards are directed at Blacks, and alcohol ads account for about 37% of that amount, second only to cigarettes (Hacker, et al., 1987).

Coupled with the higher concentration of billboards in the Black community is the equally high concentration of alcohol outlets (Dawkins, et al., 1979). Liquor stores are highly visible parts of residential areas heavily populated by Black people. Conversely, in White communities the liquor stores and bars are typically located in commercially zoned business areas (Hacker, et al., 1987).

It is not possible to draw a direct causal link from the alcohol industry's race-specific advertisement targeting to the negative health outcomes that alcohol use and abuse have on many Black people each year. Nevertheless, it seems very plausible that the money the alcohol industry pumps into Black employment, advertising, community service, and other organizations helps to silence efforts by Black celebrities, leadership, and even churches to make African Americans aware that the legal drug, alcohol, devastates more families and takes more lives than all the illicit drugs combined. The economic dependence that many Black corporations and individuals have on the alcohol industry may limit their ability (or desire) to "bite the hand that feeds them," or to make Black people aware that they are disproportionately targeted to purchase and consume alcoholic beverages.

Prevention

Prevention can be defined simply as an effort to keep something from happening. As it relates to alcohol, prevention goals may be to keep those who drink from experiencing the negative consequences associated with abuse (secondary prevention) or to keep those who do not drink from initiating (primary prevention). Most often, primary and secondary prevention are directed at youth and young adults, those populations most likely to experiment with alcohol and to use alcohol heavily. Accordingly, much of the discussion below focuses on young people.

Existing research has highlighted numerous intrapersonal, interpersonal, and environmental "risk factors" that increase

the likelihood that an individual will abuse alcohol, as well as "protective factors" which buffer, or reduce, the likelihood of alcohol abuse (for more extensive discussions see Goplerud, 1992; Hawkins, et al., 1992; Clayton, 1992). Several of these risk and protective factors are discussed below, focusing particular attention on their relationship to alcohol use and abuse among African Americans.

Risk and Protective Factors for Alcohol Abuse

Like most alcohol research, the vast majority of the research on risk and protective factors has been done using predominantly or exclusively White samples. Accordingly, the extent to which many intrapersonal, interpersonal, and environmental risk and protective factors discussed below influence alcohol abuse among African Americans is not yet known (see Farrell, et al., 1992; Newcomb and Bentler, 1986; Harford, 1986).

Intrapersonal. Past research has identified a number of intrapersonal and other individual level risk factors and protective factors related to the abuse of alcohol and other drugs. The intrapersonal risk factors include sensation seeking, poor grades, truancy, low self-esteem, depression, lack of bonding to societal institutions (family, school, community, work, church), rebelliousness, delinquency, positive attitudes toward alcohol, and expectation to drink in the future. Intrapersonal protective factors include the inverse of the risk factors (e.g., high self-esteem, strong attachment to society) and other variables like internal locus of control, self-discipline, religiosity, and positive expectations about the future. Low bonding to school (e.g., poor grades and truancy) has been found to significantly relate to alcohol use among African American youth (Farrell, et al., 1992; Wallace, 1993), but the salience of many other intrapersonal variables as alcohol risk and protective factors has not been well established.

Interpersonal. Interpersonal risk and protective factors are those that result from interaction with others. The interpersonal risk and protective factors most often cited are those related to family and peers (Catalano, et al., 1992; Barnes and Welte, 1986;

Hawkins, et al., 1992). The family and peer risk factors include modeling of alcohol abuse by parents and siblings, high levels of family conflict, parental absence, high levels of family stress, peer pressure to drink, peer rejection, high levels of peer involvement, and perceived and actual alcohol use by peers (Hawkins, Catalano, and Miller, 1992). Interpersonal protective factors include warm personal relationships with parents, family stability, and limited alcohol use by parents and peers (Hawkins, et al., 1992; Moskowitz, 1989). In general, the peer risk factors have been found to be significantly related to alcohol use among African American youth (Farrell, et al., 1992; Wallace, 1993), but again, the extent to which the other risk and protective factors impact their alcohol use has not been well researched.

Environmental Factors. Several environmental factors have been theorized or empirically demonstrated to affect the likelihood that a given individual will use or abuse alcohol. Environmental risk factors include those that relate to the broader social environment (e.g., racism) as well as those that relate specifically to alcohol. The research indicates that alcohol consumption and alcohol-related social and physical problems are highest where there are high levels of poverty, unemployment, and crime, where there are high concentrations of alcohol outlets and low alcohol prices, where Sunday sales and advertising are not restricted, and where the minimum drinking age is low (Moskowitz, 1989; O'Malley and Wagenaar, 1991). Environmental protective factors include laws unfavorable toward consumption, high taxation, low concentration of alcohol outlets, and restrictions about when and to whom alcohol may be sold (Moskowitz, 1989; Hawkins, et al., 1992).

Because a third of African Americans live below the poverty level, many African Americans are at elevated risk for alcohol abuse. Specifically, crime, overcrowding, and other poverty-related factors clearly affect many African Americans. Low income African Americans are disproportionately exposed to many alcohol-specific risk factors, including low prices, abundant advertising, and high levels of availability. The "40 ounce" malt liquor, ubiquitous in African American communities, is a particularly poignant example of availability. The "40" is over-

sized, relatively inexpensive, extremely high in alcohol content (e.g., some brands have a higher alcohol content than a six-pack of regular beer), and heavily sold and marketed within Black communities (Scott, et al., 1992).

Prevention Measures

Because the risk factors for alcohol abuse exist at multiple levels (i.e., intrapersonal, interpersonal, and environmental), prevention efforts should target multiple levels of risk (see Pentz, et al., 1989). Several recent publications have highlighted single and multiple level prevention efforts among African Americans (USDHHS, 1990; Goplerud, 1992; Oyemade and Brandon-Monye, 1990; USDHHUD, 1992).

Efforts that target intrapersonal risk factors for alcohol abuse include a variety of programs, including individual counseling, remedial education, life skills training, stress management, social influence, resistance training, values clarification, decision making, goal setting, vocational counseling, and involvement in alternative activities (see Goplerud, 1992; Hansen, 1992; Hawkins, et al., 1992). Programs intended to affect interpersonal risk factors for alcohol abuse focus on family support, parenting skills, early childhood education, the reduction of interpersonal aggression, peer and family counseling, increasing the strength of family relationships, and developing positive peer groups (Goplerud, 1992; Hawkins, et al., 1992; Tobler, 1986). Environmental prevention efforts include increased taxes on alcoholic beverages, laws restricting the days and hours of alcohol sales, minimum drinking age laws, restrictions on the location of alcohol outlets, and the creation of community level norms opposed to alcohol abuse (Moskowitz, 1989).

The Effectiveness of Prevention

Although the number of prevention programs has increased greatly in recent years, published evaluations of programs that target African Americans are virtually non-existent (see Goplerud, 1992). Accordingly, the extent to which various programmatic and policy efforts have been able to reduce alcohol

initiation or alcohol abuse among African Americans is not yet known. A major issue expected to impact the effectiveness of prevention efforts directed toward African Americans is the extent to which these efforts are culturally specific. Based on the financial harvest that the alcohol industry and alcohol outlets reap in poor African American communities, it appears that culturally specific, targeted marketing is quite effective. However, given the heterogeneity within the African American population, the "culture" to which a particular program should be "specific" is not always clear (e.g., a "culturally specific" prevention message effective with a young Black male in Harlem may be meaningless to a Black girl in rural Mississippi). The implementation of intrapersonal and interpersonal prevention efforts may be particularly difficult for non-African Americans or individuals of any ethnicity/race who lack contact with and/or who are insensitive to and ignorant about the culture of the targeted population (MEE Report, 1992).

Several prevention programs and policies have been evaluated concerning their effectiveness in the general population. The extent to which these efforts have been effective varies considerably. For example, recent research suggests that taxation and laws regulating the sale and use of alcohol are relatively effective in reducing alcohol abuse and related problems (Moskowitz, 1989). On the other hand, individual level prevention programs appear to have relatively little impact on alcohol abuse (Hawkins, et al., 1992; Moskowitz, 1989).

Beyond "Programs": Recommendations for Prevention

Intuitively, it is expected that programs adapted for and specifically created for African Americans will be more effective than generic programs; but, as noted before, prepackaged "programs" which focus exclusively on individuals hold little promise to prevent alcohol use and abuse, particularly if by programs one means one-shot or limited duration activities in which young people attend a class or two, participate in a few role plays, receive a special t-shirt, and are taught to repeat a catchy phrase.

Many "programs" are similar to get-rich-quick schemes and fad diets that promise maximum results with minimum effort. In the real world, those who can successfully amass and retain wealth or who can lose and maintain weight loss are those who are disciplined, who can obtain the requisite knowledge, and who invest the time and hard work necessary to achieve their goals.

Just as there are no easy roads to wealth, health, or any other desirable goal, there is no easy way to prevent alcohol abuse among young people, particularly when alcohol is so widely used, so universally accepted, and so aggressively marketed. There are existing program curricula and other materials that have been shown to be effective in increasing young people's knowledge about alcohol and the problems associated with its abuse (Hansen, 1992). There are also curricula and materials that teach young people how to make decisions and how to resist peer pressure to drink. In short, there is an abundance of knowledge-based skills and abilities which existing "programs" can develop in young people. Nevertheless, it is Pollyannic to believe involvement in "programs," taken alone, will keep young people from using alcohol or prevent the myriad problems associated with alcohol abuse. In order for alcohol abuse and other social problems to be prevented, young people must be embedded in functioning, interconnecting social support networks (Price, et al., 1993) committed to the goal of prevention. These networks include, but are not limited to, family, peers, community residents, schools (i.e., students, teachers, administrators), churches, youth-serving organizations, businesses, and the communities in which these young people reside.

Effective programs will certainly attempt to incorporate the best of what is available in terms of prevention curricula, but this step is only the beginning. The most effective "programs" will begin with parents and significant others who model abstinence or restricted patterns of use, who explicitly state their values and expectations regarding alcohol use, who monitor their children's activities and peers, and who create, participate in, and support activities in which their youth are involved. The most effective programs will involve long-term relationships

with caring family members, friends, teachers, church leaders and members, and others from whom young people receive love, guidance, respect, and discipline. Prevention "programs" can never substitute for these relationships.

Summary

Although there is a massive literature on alcohol use and abuse in this country, relatively little of the research focuses on African Americans. Accordingly, much theoretical, epidemiological, and etiological research is needed to clarify the patterns, norms, prevalence, correlates, causes and consequences of alcohol use and abuse among the nation's Americans of African descent. Further research is also necessary to identify the risk and protective factors that are most salient for African Americans.

National prevalence data suggest that African Americans are no more likely to use alcohol than the general population. On the other hand, research on alcohol-related mortality and morbidity suggests that African Americans are more likely than average to experience alcohol-related problems. The extent to which these problems are the result of macro-level social factors, such as poverty, unemployment, and institutionalized racism, rather than race, per se, is not clear. Nevertheless, the disproportionately high prevalence of alcohol-related illness, death, and other social problems among African Americans shows that the need to prevent alcohol abuse, particularly among young people, is imperative.

Ultimately, individuals decide the extent to which they will become involved with alcohol. Nevertheless, this decision does not occur in a vacuum; rather, it is influenced greatly by individuals' primary relationships and the social contexts in which they are embedded. Accordingly, prevention efforts must not be directed toward individuals only, but also toward the experiences, relationships, activities, institutions, and communities central to their everyday lives.

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Alcohol Prevention Research in Black American Communities

Patricia A. Seabrooks

Introduction

A review of the alcohol abuse prevention literature on Black American communities reveals a paucity of attention to the challenges facing researchers and community members who are trying to develop collaborative relationships to prevent alcohol-related problems in the community. This paper identifies some of these challenges, drawing from the perspective of community members and organizations.

The community of Miami-Dade County, Florida, is used to illustrate some of the barriers, successes, and not yet completed projects that address the commitment to collaborative relationships between researchers and community members. The community of Miami-Dade County represents a multicultural, multi-racial, economically diverse environment that is often confronted by multiple complex and conflicting health care and social issues. Alcoholism and alcohol abuse prevention and treatment represent the more challenging issues with which the community is faced.

After a description of the Miami-Dade County community and a brief review of alcohol-related problems of the community, the remaining sections of the paper address some challenges

facing researchers and community members in Black American communities as they attempt to build collaborative relationships.

Miami-Dade County, Florida

Description of the Community

There are three primary ethnic groups who reside within the boundaries of the Family Health Center (FHC) in Miami-Dade County, Florida. These include American and Caribbean Blacks who live in the Liberty City and Brownsville communities, Hispanics primarily from Cuba but also from other Spanish-speaking countries such as Nicaragua and Colombia who reside primarily in Hialeah and Allapattah, and Haitian immigrants (both documented and undocumented) who live predominantly in the Edison/Larchmont areas commonly referred to as "Little Haiti."

Although the community health center serves several ethnic groups, Black Americans from Liberty City, an area in which over 80% of the residents are at or below the poverty level, constitute the single largest group. This is in contrast to the rest of the county where 50% of residents are at or below the poverty level. The area known as "Little Haiti" consists primarily of Haitian immigrants (legal and illegal), while Hialeah consists mainly of blue-collar Cuban Americans and Nicaraguan immigrants (legal and illegal).

Most of the families served by the community health center are headed by single women. The extended family provides essential support in the form of information, childcare, and transportation services. Many of these women receive public support from the programs that are designed to help families with dependent children, such as the Food Stamp program, Aid to Families with Dependent Children (AFDC), and the Women, Infants and Children's (WIC) nutritional program.

The community is plagued with a host of problems including high unemployment (particularly among the youth), high rates of crime, school dropouts and infant mortality, and an ever-increasing epidemic of substance abuse with the associated HIV/AIDS related illnesses.

Migration Patterns to the Community

The existence of large numbers of immigrants within these communities presents complex challenges to the formal social support system both in identifying social problems and in providing services to meet the needs of the communities.

Immigrants who enter the country legally or illegally often find themselves in an unfriendly host environment. Stress associated with major transitions is heightened in the case of immigrants when the host community is not only unfriendly, but hostile. Haitians, more than other immigrants to South Florida, have experienced a particularly hostile reception.

Regardless of the ethnicity, when given the choice, immigrants typically seek out and settle with family members or in communities of other immigrants from their home country. These communities provide various kinds of support. Most important, survival strategies are quickly shared and information exchanged on how to function within the social system and how to access many services that are not readily available to long-term residents.

The perception that recent immigrants receive benefits not easily accessed by other groups, especially by American Blacks, causes a certain amount of tension among the ethnic/racial communities. One often hears Black Americans complaining of the frequency with which immigrants are allowed services that are denied their own ethnic sisters and brothers. These remarks perpetuate a perception of societal favoritism to refugees and other immigrants regarding entitlements and access to formal social services.

Religious Traditions in the Community

American Black and other ethnic/racial communities place great value on religious organizations in the community. Historically, the church has served as a primary source of support and information to families. Information that is transmitted to the community from this source is more likely to be received and to be believed than that from other sources because the information is seen as promoted and sanctioned by trusted religious leaders. In general, social programs targeted at the Black American com-

munity are looked at with suspicion when they do not involve the church in some form.

Examples of this are many. In one case, the Florida State Department of Health and Rehabilitative Services (HRS) funded an educational program for awareness and prevention of HIV infection through churches in the ethnic/racial community during the 1987-88 initiatives to prevent HIV exposure in South Florida communities. The Gamble Memorial Church of God in Christ in Allapattah, a neighborhood in Miami, and the Duke's Temple Church of God in Christ in Liberia, a community in Hollywood, Florida, were asked to spearhead the program. Also a major Black Baptist college, Florida Memorial College, in Opa Locka, Florida, received funds from the Lilly Foundation to educate ministers and lay members on how to offer programs in the church on the prevention of substance abuse and HIV infection.

Social Support and Information Sharing

Other ways in which various ethnic groups in South Florida support one another and exchange information can be seen in the tradition of men assembling at common meeting places to play checkers or dominoes, drink, and share life stories. This practice is often viewed by middle-class Americans as slothful and without any redeeming value. While these gatherings do not produce results that are easily measurable, their usefulness as a source of social support and information sharing should not be underestimated.

Neighborhood flea markets serve as a major gathering place for members of Black communities in South Florida. Shopping at the flea market is a common weekend pastime for men, women, young, and old alike. Bargaining and casual conversations are the business of the day at these markets. Because of the access they provide to members of the community, they have been successfully integrated into the outreach efforts of church programs on AIDS education and prevention.

Alcohol-Related Problems in the Black American Community

The Black American communities in South Florida contain a disproportionate number of individuals with alcohol depen-

dency problems. Evidence of this appears in police reports, juvenile justice reports, and the number of admissions to treatment programs for substance abuse.

Black Americans represent 11% of the total population in Dade County. However, sixty-seven percent (67%) of the trauma cases related to substance intoxication treated at the county hospital in 1990 involved Black Americans. Fifty-seven percent (57%) of all cocaine-exposed babies born in the county in 1990 were born to Black American women. In many cases, the users of cocaine are also dependent on alcohol (Jackson Memorial Hospital Data, 1990).

In 1987-88, 1,930 infants in the state of Florida were reported to HRS as having been exposed to a drug before delivery. By 1988-89, the number had increased to 4,835. It was projected that by 1990-91, more than 6,000 substance-exposed infants would be born in the state. These numbers represent only the number of reported cases. It is common knowledge in the community that private physicians and private hospitals frequently do not report this information (Florida State Department of Health and Rehabilitation Services, 1990).

Part of the problem with alcohol use and abuse within the Black American community can be found in the casual attitude that prevails regarding alcohol use. Problem drinkers are often tolerated and the behavior dismissed as an idiosyncrasy rather than a medical problem. Sometimes the drinking is seen as symptomatic of a moral weakness.

Alcohol use and over-use are common behavior engaged in by young men to signify the passage from adolescence to adulthood. Typically, the young men who assemble with the older men to play checkers try to "hold" their liquor by drinking large quantities of alcohol. This behavior is often encouraged by the older men.

A similar behavior occurs in the military services. Young soldiers are challenged to drink more than they might ordinarily to prove that they have become men. This rite of passage is slowly fading, but can still be seen at officers' and enlisted soldiers' clubs during "happy hours" or special social events.

Another contributor to abusive drinking behaviors is evident in the aggressive advertising that is directed at the Black Ameri-

can communities across America. A quick perusal of Black American periodicals such as *Ebony* or *Essence* reveals many advertisements with glamorous models who promote drinking as a primary ingredient in any successful relationship or career. Billboard advertising continues to plague the community with various forms of alcoholic beverages.

One frequently hears Black Americans attempting to justify abusive drinking habits by insisting that theirs is a natural excess stemming from a history of poverty and the inability to enjoy some of the benefits of the American "good life." Teetotalers or individuals who do not drink alcohol at all are often ostracized by the larger ethnic community because of their failure to drink socially. Such rationalization only serves to obscure the serious issues surrounding alcohol abuse—issues that are being addressed, slowly and painstakingly, through the concerted efforts of a variety of community health centers.

The Family Health Center

Family Health Center (FHC), one such community health center, is a comprehensive primary care facility with a state of the art alcohol and substance abuse program that is directed by its Department of Addictions and Preventive Health Services. The Center, the largest ambulatory primary health care center in the South Florida area, with five satellites in the major ethnic communities, has been in the community for more than twenty-three (23) years, providing preventive health care, treatment and rehabilitation services to families in need.

FHC's prevention and treatment program has been available to the community for almost as long as the agency has been established. Initially, the alcohol treatment program was federally funded as the Uhuru Center for the treatment of Alcoholism and other Drug Abuse. The goals of the program have been to provide prevention education to all of the service users of the Center and to offer treatment and continuing rehabilitation and support to identified abusers of alcohol and other drugs.

A review of the Center's historical documents and interviews with individuals who have been with the Center in positions of responsibility for many years showed that researchers interested

in the prevention of alcoholism and alcohol abuse had not contacted the Center to collaborate on a project regarding the prevention of alcoholism. Professionals who have shown interest in the substance abuse program have done so from the treatment perspective. The Center has not been requested to participate in survey research surrounding alcoholism prevention or treatment.

FHC Successes

While the milieu in which the Center exists continues to reflect the great socio-political turmoil that characterizes South Florida in general, FHC is pleased with its major achievements and their overall impact on the health care status of the service population.

In 1990-91, preventive health care programs were designed primarily for children's health services. These programs included an early alcohol and other drug abuse prevention/intervention program for elementary school children and a preventive health care program for the children in the learning center that was established as a support for mothers in the residential treatment program for alcohol and other drug abuse.

Family Health Center also provides prevention education for alcohol and other substance abuse for pregnant adolescents through the alternative public school for pregnant and post-partum students, as well as contracted health services to Florida Memorial College students. An aggressive alcoholism prevention program is provided to the community through the Department of Addictions and Preventive Health Services.

Although research efforts have not been aggressive, the Center's alcoholism and other drug abuse prevention programs have resulted in many pregnant women entering treatment for substance abuse behaviors. Those entering and completing treatment serve as role models to others on how women in the inner city can change a life style that is replete with self-destructive behaviors. Therefore, the treatment program has been FHC's best prevention program for alcoholism and other drug abuse among its service users.

Health data reveal that, when compared to the general population in Miami-Dade County, the users of FHC's services fare

much better in recovery and rehabilitation from addictive behaviors. For example, none of the Center's prenatal clients delivered addicted babies at a time when the number of addicted newborns continued to increase in the general service area. This is a major accomplishment and can be attributed to the enrollment of all pregnant mothers with substance using and abusing behaviors into an appropriate treatment program and to providing each client with a case manager who can help in finding access to necessary services for the women and their families.

Projects in Process

The major research institution in the area, the University of Miami, School of Medicine, Department of Psychiatry, included the Center in the development of a grant proposal for the funding of a prevention treatment for Black youths. The project has yet to receive funding. Nevertheless, both agencies are interested in developing a collaborative relationship for future projects. The inability of the Center to conduct its own research has to do with limited resources and its commitment to service, which includes education of the community. The lack of research professionals on the Center staff has also impeded the research process. Even when professionals with appropriate preparation and interest have been on staff at the Center, service has always taken precedence over research because the funding of the service is dependent upon its actual provision and documentation.

In 1992, the Center was awarded a Robert Wood Johnson Foundation grant to conduct an evaluative study of the residential substance abuse treatment program and its relationship to the childcare program. This represents the first such funded research project. The project is still evaluating the treatment component of the program. Results of the findings on prevention will not be known for many years, and the childcare component of the project is committed to following the children until they reach grade school. Beyond the first grade, no plans have been made for following the children who are now in the childcare program.

Building Collaborative Relationships

In this section, several topics are examined that are about building collaborative relationships between researchers and community members: (1) the socio-cultural model of alcohol abuse prevention; (2) the role of the "culture broker"; (3) barriers to collaborative relationships; (4) the public use of language; (5) the perceived attitudes of researchers; and (6) the publication of research findings.

The Socio-cultural Model

There are many models used by researchers engaged in alcohol abuse prevention research. Tuchfeld and Marcus (1984), for example, reviewed three prevention models: (1) social-structural, (2) public health, and (3) socio-cultural. For the exploration of collaborative relationships, however, application of the socio-cultural model is most appropriate. The model implies that alcohol abuse can be prevented when social activities are used to introduce and control the drinking of alcohol, especially when introduced at an early age. Furthermore, this model also suggests that by using a trusted public figure to promote responsible drinking, the prevention of alcohol abuse can be effected. In other words, it supposes that the specific culture poses some influence on the development or the prevention of alcohol-related problems.

Researchers who are interested in studying prevention strategies in Black American communities can best serve the community by considering the specific factors involved in the socio-cultural model. Notwithstanding, the other models also present alternate frameworks for study. However, when the cultural group is specifically identified, it is because of the uniqueness of the culture and the different components of the culture that one looks to such a model to provide explanations and understanding of antecedents and consequences of behaviors.

Black American culture (more recently called "African-American culture") is as diverse as "American Culture." It is

helpful and appropriate to use anthropological concepts to understand the emic views of the communities being studied. Each community has a culture of its own. There may be some underlying connections based on the common African heritage. These, however, may range from skin color only to a shared appreciation of the religious institutions that have been traditional sources of strength and support within the Black community.

The Role of the "Culture Broker"

Researchers wanting to be effective in the Black American communities will involve members of the cultural group in any studies that are undertaken to look at alcohol abuse prevention interventions. These individuals must understand cultural phenomena, culturally defined antecedents and consequences of the behaviors under study, as well as other nuances of the culture. This individual, sometimes called a "culture broker," also understands the larger scientific community and can communicate with both audiences (Weidman, 1985). A "confidante," on the other hand, is a member of the cultural group who can help with gaining entree into a society or the collection and interpretation of cultural phenomena, but may not appreciate the scientific requirements for accuracy and, therefore, may "interpret" data in a biased way.

Barriers to Effective Collaboration

Collaborative arrangements can be established when the researcher contacts respected individuals from the community. These individuals can direct the researcher to data sources, either to begin new studies or to supplement existing studies. Too often projects are begun but not completed because of decreased interest or lack of commitment by the individuals involved. Studies may have begun before the investigator had an adequate understanding of the environment and the cultural group being studied.

Just as collaboration between the investigator and members of the community enhances a study, failure to collaborate may

create barriers and inconclusive results. Studies performed without the kind of trust provided by the culture broker often lead to pro forma responses in which subjects give to the researcher what they believe is expected, whether accurate or not.

Oetting and Beauvais (1991) identified three types of failure regarding alcoholism prevention projects: (1) failure to initiate, (2) failure to be effective, and (3) failure to thrive. These three types of failure are very descriptive of how prevention interventions can be unsuccessful. Inadequate planning, inadequate funding, or failure to include members of the community as part of the research design often contribute to failure to initiate. Failure to be effective is evident when a program is carried out but fails to realize its stated goals. Such programs may answer some questions but fail in the primary objective of the study. Failure to thrive is manifested when programs that begin with ample support from the target community, the scientific community, and the general public lose the attention and commitment of these constituencies over time.

Language as a Barrier

An important issue that is often raised in the Dade County community is that of an "official" language. Sensitive to the increase in immigration, voters in that county declared English to be "the official language of Dade County." This issue was very divisive in the community since it seemed to achieve little in any real sense, but rather exacerbated barriers to social services. Language is a formidable barrier under any circumstances, but particularly so when the language spoken by the service seeker is different from that of the service provider. The "English Only" law was most recently repealed by the Dade County Commissioners.

The barrier of language can be overcome most easily when the researcher learns the language of the client population. This is not always possible. Regardless, members of the target group should be identified as translators and interpreters as well as research assistants, confidantes, and culture brokers.

In the Black American community, the language spoken is English. Despite differences in dialect, the community members

expect outsiders to address them in standard English. Researchers are well advised to use terminology that the average person can understand. The use of street vernacular and "ghettoese" is not expected or even recommended for establishing rapport or gaining confidence for those researchers spending a limited amount of time in a particular community. Outsiders who try too hard to assimilate may find themselves raising suspicions as to their motives and intentions.

On the other hand, a researcher who has worked in the community for some length of time may be expected to incorporate some element of that community's values, mores and language. While certain individuals may have difficulty mastering a second language, it is imperative that researchers avoid the air of superiority so often seen among White American scholars, particularly around the issue of language.

Perceived Attitudes of Some Researchers

Still another barrier to building collaborative prevention research projects in the community has to do with the preconceived beliefs of researchers, many of whom are entering Black American communities for the first time. Some approach research as if providing a missionary service to a pitiable humankind. This kind of condescension does little to engender a spirit of cooperation. Others bring with them an obsessive concern about crime, seeming to equate all Black males with violence and criminality.

Still others offer grand plans for treatment programs with little consideration for prevention programs. This is not only true in alcohol prevention, but also with other health care issues as well. In each of these instances, researchers take their inspiration less from the community they are studying than from their own preconceived notions of what the community may need.

The Publication of Research Results

Last, the paucity of published study results among alcohol abuse prevention programs poses a serious barrier to progress. More often than not, prevention programs do not have the results printed, so that the efficacy of the projects remains unclear. The publication of findings is needed to determine success or failure.

The Family Health Center has sponsored an alcohol and other drug abuse prevention/intervention program with elementary school children for more than eight years. This collaborative effort with the county school board appears to have been successful, and the school board has entered collaborative relationships with other community agencies to establish four more of the programs in other schools.

At the same time, requests for evaluation of the program regarding prevention of substance use/abuse and participation by parents in the children's educational program have gone unanswered. This, quite clearly, is because the results do not exist. The program managers emphasized prevention at the expense of evaluation. Evaluation and analysis of outcome criteria are an essential part of any prevention program, and their importance cannot be underestimated.

Conclusion

Universities and other research agencies can and should create relationships with public health agencies and other community-based organizations to continue to study alcohol-related problems within the Black American community. Ideally, the researcher initiates this relationship because of interest, research expertise, and access to resources.

Although it is the researcher who initiates the relationship, it should be conceived of as collaborative so that the investigators and community organizations are viewed as equal partners in the project. Too often academic researchers use community-based organizations without ever acknowledging the contributions of these agencies or giving them appropriate credit. Having had bad experiences, many of these agencies refrain from participating in studies that could well benefit their service users. Mutual respect is the necessary antidote and will go a long way in rectifying this dilemma.

Collaborative relationships are more likely to be successful when the orientation and the conceptual framework upon which a study is designed fit the philosophy and orientation of the community-based organization. For example, a study focusing

on genetic determinants of alcoholism is destined to fail in a community church or health center. Biological studies are best carried out in large medical centers or acute care facilities. Sociological and behavioral studies, by contrast, are well suited to the community health care setting.

Grant and Johnstone (1990) proposed that an interdisciplinary approach to the study of alcoholism and alcohol abuse was critical in moving forward in prevention intervention. Finding the appropriate balance in this interdisciplinary approach (somewhere between qualitative and quantitative research, between biological and sociological investigation) remains the challenge to researchers studying alcoholism and alcohol abuse in the Black community.

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Comments on Alcohol Prevention Research in Black American Communities

Janet L. Mitchell

Yesterday, Dr. Langton reminded me that when she contacted me about this conference, I suggested she might want to conceptualize the conference differently. I suggested that researchers did not all sit at academic institutions. One idea that came across yesterday, and hopefully was dispelled by today's first two speakers, is that being at an academic institution does not legitimize you as a researcher. You can be in the "community" and be a researcher. Drs. Brown and Seabrook exemplify that.

I would like to remind Dr. Brown about our first collaboration. When I returned to New York in 1988, having spent five years in Boston, he and I set out to submit a grant to NIDA. Some of you are familiar with Dr. Brown's credentials. Dr. Brown is the Vice President for Medical and Research Affairs for a large minority-owned methadone maintenance treatment program in this country, the Addiction Research and Treatment Corporation (ARTC). He has a part-time job at Harlem Hospital Center that provides him an academic appointment at Columbia University, College of Physicians and Surgeons. He spends most of his time

at ARTC. When I returned to Harlem Hospital (I had trained at Harlem Hospital in OB/GYN) to take over the largest prenatal program for substance-abusing pregnant women in the City of New York, I also was given a Columbia University appointment. However, all of my time and all of my work was at Harlem Hospital. I have been doing work in substance abuse and pregnancy for many years.

Dr. Brown and I wrote a grant in response to an RFP from NIDA to study the impact of drug abuse on pregnancy. One comment on the pink sheet (the summary of the critique of our proposal) stated that the principal investigators did not have a clear understanding of the problem or the population. We both had a long history of successfully providing services to the targeted population. We both worked in communities with great numbers of the targeted population. Could it have been because we did not sit at an "academic institution" that the review panel felt we did not have the needed skills to carry out the project? Could it have been because our perception of the problem and our approach offered an approach not deemed acceptable by the reviewers? We were, in fact, community-based in our orientation.

"Who" is researching "whose" community? Every speaker yesterday was a researcher. Perspectives, however, may be different depending on whether one is based at an academic institution or in a community-based organization (CBO).

Those based at CBOs (Harlem Hospital Center is considered a CBO) are well acquainted with the problems to which Dr. Seabrook referred in her paper. The needs of community-based researchers are different. If you are reviewing a grant from a CBO that asks for a full-time secretary, it is because there is no one to answer our telephone. In fact, there is an answering machine on my phone so that it does not go unanswered. An answering machine that I *bought* out of my pocket. If there are typographical errors, it is because we do our own typing. With no secretary and little to no other support, grants are written after work and on weekends, often into the early hours of the morning. So if you wrote "T-O-O" but intended "T-W-O," spell-check (if you have access to a computer) would not alert you. Few community-based researchers have secretaries or other col-

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leagues to help with rewriting and editing. Despite the many problems with being a community-based researcher, several excellent ones exist, and some of them are attending this meeting.

Let's now focus a bit more on "community." Just as with other communities, the African-American community is not monolithic. It is important to acknowledge this diversity, as Dr. Seabrooks discussed "who is the community" and "what community" has been researched. For the most part, the "community" that has been researched and written about is known in our vernacular as the "Hood." Essentially these are communities of color that are predominantly poor and urban. Unfortunately, the findings are often extrapolated to myself, Dr. Brown, and Dr. Seabrooks. I do not know where Dr. Seabrooks lives, but Dr. Brown does not live in the "Hood" and neither do I.

Unfortunately, almost all research on African Americans is basically done in impoverished neighborhoods. Often the socio-political-economic climate makes it difficult to tease out what the real variables are when one attempts to evaluate or interpret data from these studies. Is it poverty? Is it ethnicity? Is it culture?

My interest in substance abuse in pregnancy grew out of my concern with the high infant and maternal morbidity and mortality rates in the African American community. The research in this area has also focused mainly on poor communities. The inter-relationships of economics, political structure and societal problems make it difficult to find causal effects. The Centers for Disease Control's Division of Reproductive Health, with an African American researcher, Dr. Diane Rowley, as division head, decided that one way of teasing apart these variables might be to look at a subpopulation of African American women. That subpopulation was a population of college-educated Black women, *married* to college-educated Black men. The infant mortality rate of this subpopulation was compared to that of college-educated White women married to college-educated White men.

Two interesting points emerged. One, the gap in infant mortality still existed, but more than 80 percent of the gap could be accounted for by the rates of preterm labor and delivery. For term infants, there was no gap. We know many of the causes of preterm labor. We know that both physical and psychological/emotional stress can lead to preterm labor and delivery.

Given the decades and money spent on trying to narrow the infant mortality gap, it is surprising that this approach had not been considered earlier. This association would probably not have been found had we not looked at a subpopulation who were more like the "White norm" than the "Hood." Interventions and prevention strategies can now be focused. That stress can produce physiological effects is well known for other diseases, notably cardiovascular diseases. One theory that attempts to explain the high rates of hypertension among African American males is called the John Henry-ism syndrome. It suggests that the stress of needing to "prove" oneself to work harder just to be accepted, creates high levels of internalized stress that manifests itself physiologically by an increase in blood pressure. In more simple terms, it is the stress of oppression.

While oppression has been discussed at this conference, the more applicable term, racism, has not. Certain stresses are internalized by populations who have been oppressed simply by the way they look—the color of their skin. I would be very interested to know why Dr. Seabrooks left her associate professorship to work in the community. If she is anything like me, I spend a few years in the White world and submit myself to all the stresses and strains of being African American and female in a White and usually male-dominated environment. When I feel that I have had enough of that type of stress, I go back to the Black community and I deal with *that* stress—a different kind of stress—but equally stressful. I move back and forth for my own sanity. The types of stresses that occur when I am in a White world are different from the types of stresses that I encounter when working in my community.

Additionally, we need to understand that sometimes, unbeknownst to researchers, their perception of what it is they want to find has little to do with reality. If African Americans are so deficient (we talked about, deficit research yesterday), then why look at prevention? If we are serious about the prevention of alcoholism and the abuse of other drugs, why not look at that segment of the community that does not have a problem? Should we not know what keeps those members of the same community from taking that first drink? Why are we more comfortable

when dealing with only the pathology of African American communities? Could it be because that is what gets published and feeds into the stereotypes that this country wants to perpetuate? Is it these stereotypes that allowed the jurors in L.A. to think that Rodney King *deserved* the beating he got? Deficit research perpetuates the stereotypes.

Most community-based researchers do not ascribe to the deficit research model. This is but another of the difficulties community-based ethnic/racial researchers have in getting papers accepted for publication, in being even accepted as a researcher.

There is no reason to distinguish "community researchers" from "academic researchers." We are all researchers. The only difference may be in the way in which we interpret the data or in the way in which we approach a problem. That is why we are here today discussing "community researchers," the "community response," the "community approach."

I was part of a HIV/AIDS panel last week, discussing characteristics associated with high risk behaviors. In a survey done by researchers from the CDC, religious affiliation was a marker for decreased rates of risk taking behaviors in White females but not in Black females. The presenter remarked that he and his colleagues had no explanation for this difference. The explanation was apparent to every African American in that room. Our culture is one in which most of us are exposed to an organized religion early in our lives. Nearly every one of us started out in Sunday School. Most of us were baptized as children, so almost all of us have a "religious affiliation." The question *not* asked was about those who *continue* to attend religious services. That was the more appropriate question to ask. Asking the "wrong question" may not only provide you *wrong* information but also may yield you *no* information. You seldom get past five years old without being baptized as an African American. It does not mean that you now go to church as a 30-year-old, but it does mean you have a religious affiliation. Most ethnic/racial researchers who grew up in an African American culture would have foreseen the problems with that question before doing the survey and would have explained the differences in the results between Blacks and Whites.

If this meeting is about prevention of alcoholism in the Black community, then we need to know what keeps one from taking that first drink. We need to focus on the populations in communities (subpopulations) that have lower rates of the problems we find of interest, to understand why they have lower rates.

This is but one reason ethnic/racial researchers who are "of the culture" make research better. We can look at a questionnaire and explain why a question may not yield the information desired. We can explain why the question may have worked well in other populations but because of subtleties and nuances in language and culture it may need to be reworded.

If we are to approach prevention from the more positive perspective that seeks to find out *why* people do not initiate high-risk behavior, or why they cease indulging in that high-risk behavior, then we must not only change the philosophy of funding agencies but also the composition of review committees (IRGs) that determine what research is funded. The preference of most agencies to have grants reviewed by persons "at the associate professor level" almost by definition excludes those of us who are community-based. You would be surprised how many grants would not get funded or how many research methods that looked wonderful on paper would be torn apart when people who actually are in those communities tell you why this will not work.

The under-representation of minorities in AIDS clinical trials is a perfect example of noted academicians at highly respected academic institutions being funded but unsuccessful in recruiting minorities. Most of these institutions had no track record with providing service in a respectful way to minorities. Many were even *distrusted* by the very communities from which they proposed to recruit. Not having minorities from these communities on review committees meant there was no one who raised questions about the feasibility of these institutions accomplishing their stated goals. The National Institute of Allergy and Infectious Disease (NIAID) funded institutions that historically had turned their backs on the populations they now wanted to study. The thought was that if these institutions received money, opened their research doors, and offered clinical trials, then ethnic/racial

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groups would get involved in the studies. What was not understood or represented on review committees was the perspective of the communities, who responded by saying, Why should I now go to an institution that always sent me to their emergency room (or gave me carfare to go to the public facility) but did not want to see me come through their front door?

This costly mistake, fiscally and politically, changed the way NIAID did business. NIAID opened its review process to include persons from non-traditional settings with a greater emphasis on knowledge and experience with "hard-to-reach populations" and less on traditional academic credentials. Consequently, NIAID significantly increased the numbers of ethnic/racial and community-based researchers involved at all levels, not just the review process. Now, when grants are reviewed from institutions that claim they can recruit and retain certain populations into studies, there are people on the IRG who say, "Tell us what your history is with serving this population," "Convince me that you can deliver."

As you contemplate an agenda for research in communities of color, understand that success is dependent on "how" you proceed and "who" are your partners. You may need to not only rewrite your RFP, but to reconfigure your IRGs. You need to examine the philosophy of the agency and the philosophy of the members of the agency responsible for articulating that philosophy and allow for the fact that it may be biased.

Additionally, keep in mind that most African American communities have a historical distrust of *all* researchers. They come in, take things out of the community, leave nothing in return, and misinterpret what is actually going on. Do not expect communities to accept you with open arms because you think your intentions are honorable. Remember, they did not *ask* to be studied!

It took the crisis of HIV/AIDS to get NIH and NIAID to understand that if you really want to get the answers from communities of color, you do have to leave something behind. In the case of HIV/AIDS, it was access to clinical care. The traditional researcher's concern about "polluting" results when you mix research with clinical care was unjustifiable in communities that

historically lacked access to basic health care. You need to enter into *partnership* with the communities from which you are trying to get information. You need to gain their trust.

Many people around the research table still have some learning and growing to do. Researchers need to acknowledge and accept the following:

- Understand that in African American communities, there is still the fear of genocide and of being used as guinea pigs.
- There is the perception that you, as researchers, are taking from the communities and not leaving anything. That the community is a "means to an end" to benefit *your* career. That neither you nor your research findings benefit the community in any way that the community can document.
- There is also the fear that the basis of your prevention programs is "I (the researcher) will tell you what I think you should do and how you should do it (my design, my theory, my hidden agenda?)," as opposed to "Tell me how you think I can help you." HIV/AIDS prevention programs targeted to ethnic/racial groups originally took that approach. Essentially, prevention messages that worked with gay White males and reduced their high-risk behaviors were modified, slightly, and translated into other languages. The faces were made to look like the ethnic/racial group. The theory was "if it worked with gay White males, it should work with other populations." It did not!

You have before you an opportunity to learn from the mistakes of others and to forge alliances with communities of color as never before. If you take to heart what has been said here today by Drs. Brown, Seabrooks and others in the audience, the chances of success in finding useful information for the prevention of alcoholism and other drug abuse in the African American community will be greatly enhanced.

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Alcohol Abuse Prevention Research in Asian American and Pacific Islander Communities

Kiyoko M. Parrish

Introduction

Asian Americans are descendants of Chinese, Asian Indians, Filipinos, Japanese, Koreans, and Southeast Asians (for example, Laotian, Cambodian, Malaysians, Thai, Vietnamese). Pacific Islanders are Polynesian (for example, Hawaiian, Samoan, Tongan) and Micronesian (for example, Guamanian, Melanesian). Asian Americans and Pacific Islanders are linguistically and culturally diverse populations. However, in previous research the heterogeneity of Asian Americans has not been addressed. In some research, these groups are aggregated into Orientals (Welte and Barns, 1987), or Asians (Maddahian et al., 1985). In recent years, more attention has been paid to the differences among

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selected Asian American populations on the West Coast (Kitano and Chi, 1986–1987). However, even within the same country of origin, there are culturally distinct ethnic groups, such as ethnic Chinese among Vietnamese, and Hmong from highlands Laos among Laotians.

This paper first describes a brief historical background of Asian American and Pacific Islander immigration, and provides a demographic profile to give a better understanding of the heterogeneity and complexity of Asian American and Pacific Islander populations. After a review of the genetic susceptibility to alcohol among Asian Americans, the differences in drinking practices among Asian American populations are examined and drinking problem prevention research is discussed.

Historical Background of Asian American Immigration

Immigrants generally do not represent a random sample of populations from their native countries. Even within the same country of origin, reasons for immigration change over time, and so does the socioeconomic status of the immigrants who enter the United States. Therefore, immigrants from the same country may not necessarily share cultural norms and drinking practices.

From the beginning of this century to 1980, approximately three million Asians immigrated to the United States (Arnold, et al., 1987). Chinese were the first Asians to immigrate in large numbers to the United States, escaping economic depression, political unrest, and a series of natural disasters in China. From 1854 to 1883, nearly 300,000 Chinese, mainly from Southern China, immigrated to the booming West Coast to work on the railroads and mines, in agriculture, and in personal services. Their willingness to work for low wages resulted in conflict with labor unions during a recession, and the Chinese Exclusion Act was passed in 1882 to bar Chinese immigration to the United States.

After Chinese were barred from immigrating to the United States, Japanese were brought to work on sugar cane plantations in Hawaii and the fruit and vegetable farms in California. Japa-

nese immigrants followed the same fate as Chinese. A series of immigration laws were passed to limit the number of immigrants from Asia, including the Gentlemen's Agreement in 1907, and the National Origins Act in 1924 (Arnold, et al., 1987). Until the McCarran-Walter Act was passed in 1952 liberalizing immigration for Asian immigrants, the number of Asian immigrants was restricted. In 1965, the National Origin quota system was abolished, which opened the door for Asian immigrants (Arnold, et al., 1987). In that year, 17,000 Asians entered the United States. The flow of Asian immigrants has grown rapidly since then. By 1978, Asia had become the largest source of immigrants to the United States, surpassing North and Central America.

Approximately 90% of Asian immigration was based on family preference—a priority status to unite spouses, unmarried sons and daughters of permanent resident aliens, and their children. The percentage of immigrants entering the United States under occupational preference varied greatly over time even within the same country of origin. Based on this category, between 1970 and 1974, more than 50% of Filipinos who immigrated to the United States were professionals or highly skilled workers. By 1980, this percentage had dropped to 1.6% and then rebounded to 20% in the mid 1980s (Arnold, et al., 1987).

Pacific Islanders

The South Pacific consists of some 23 states, in which approximately 1,000 languages are spoken. This huge territory encompasses 30 million square kilometers of ocean and 550,000 square kilometers of land area and reflects cultural and economic diversity (Connell, 1987). The 1980 census was the first one to count Pacific Islanders in the United States, and 87,320 Pacific Islanders (excluding Hawaiians) were enumerated. Samoans were the largest group, accounting for 45% of Pacific Islanders, followed by Guamanians (35%) and Tongans (7%) (Xenos, et al., 1987). American Samoa is an unincorporated territory and is administered by the U.S. Department of the Interior. Western Samoa is not a U.S. territory; however, Western Samoans can manage to enter the U.S. by way of American Samoa. Guam is a U.S. territory, and in 1951 Guamanians were granted U.S. citizenship.

Enlistment for U.S. military service is a favored option among young Samoans and Guamanians, offering an opportunity for travel, training, and a higher income by Islander standards. Younger generations of these groups enter the United States for higher education, assisted by the federal Pell Grant program (Xenos, et al., 1987).

Southeast Asian Refugees

Refugees from Southeast Asia added another dimension to Asian immigration history. From the end of the Vietnam war in April 1975 to December 1975, approximately 130,000 Southeast Asian refugees (95% Vietnamese, the rest mostly Kampuchians) entered the United States (Gordon 1987). They were mostly from urban areas and belonged to elite classes (Uba, 1992). In 1980, a second wave of Southeast Asian refugees arrived due to economic hardship and political oppression in their native countries. This second wave included ethnic Chinese in Vietnam and Hmong from highlands Laos (Gordon, 1987). These refugees were more likely to be from rural areas, were much less educated, and were less proficient in English than the first wave refugees (Uba, 1992).

Geographic Distribution

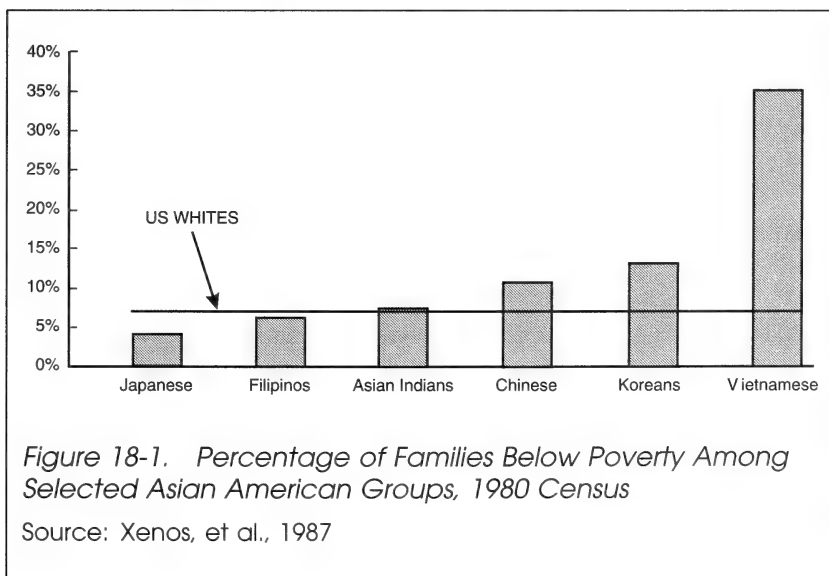
Although well over 50% of Asian immigrants reside on the West Coast, the distribution of Asian Americans shows considerable variation in geographic locale. Over 80% of Japanese Americans live on the West Coast, while only 19% of Asian Indians live in the West, with the highest concentration in the Northeast (34.3%). Southeast Asian refugees are more evenly spread throughout the United States. This is in part because the United States government has tried to spread the impact of refugees to various regions of the United States to ease the transition to a new life (Gordon, 1987). Nonetheless, Vietnamese tend to cluster in the West and in the South, and Laotians tend to settle in the Western and North Central states (Bouvier and Agresta, 1987). Pacific Islanders are concentrated in urban areas on the West Coast and in Hawaii (Xenos, et al., 1987).

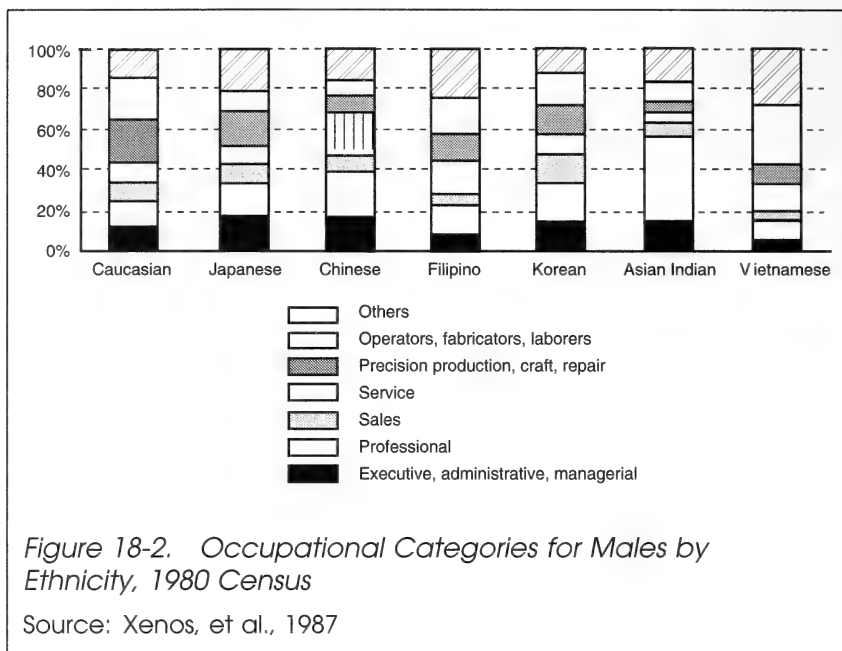
Socioeconomic Status of Asian Americans

Higher educational attainment is associated with lower abstention rates among Asian American populations (Klatsky and Armstrong, 1991). Observed differences in drinking practices among Asian American populations can be partially explained by the differences in socioeconomic status among Asian Americans.

Compared with the other ethnic minority groups, namely Hispanic and African Americans, Asian Americans have higher income levels overall. Figure 18-1 shows the percentage of families below the Federal Poverty Level in 1980. The percentage of families below the Federal Poverty Level for Japanese, Filipinos, and Asian Indians was comparable to or slightly higher than that for U.S. Whites, while the percentage of Vietnamese families below the poverty level was five times as high as that for the U.S. Whites.

As educational attainment and command of English differ among Asian Americans, the type of occupations in which they engage also varies. Figure 18-2 shows the percentage distribution of occupational categories among men in 1980. The most presti-





gious and best paid United States census occupational categories are: (1) executive, administrative, and managerial, and (2) professional specialty. In 1980, approximately 23% of U.S. Caucasian men were in these two categories. Over 56% of Asian Indian men were in these occupations, whereas only 15% of Vietnamese men were in these higher paid occupations. Chinese, Japanese, and Korean men also tended to have prestigious occupations. Women showed a similar pattern, although percentages in these two prestigious occupations are lower than they are for men in all groups except Filipinos (Xenos, et al., 1987).

Southeast Asian refugees suffer from high unemployment rates due to poor English skills and a lack of appropriate work experience for the U.S. job market. The unemployment rate for Southeast Asian refugees was 86% soon after entering the United States. The rate remained at 30% after four years of residency. However, if two or more household members were employed, only 7% of the households were below the poverty level (Xenos, et al., 1987).

Pacific Islanders tend to have lower income and educational attainment than the national average. Per capita income for

Samoans is only 49% of the national average, and it is 76% for Guamanians. Similarly, 28% of Samoan families were below the poverty level in 1980, compared with 12% of Guamanians, and 10% for the nation as a whole. Samoans are overrepresented in service jobs and as operators or laborers. Although the percentage of high school graduates for these two groups were close to the national average, the percentage of college graduates was about half the national average. In recent years, younger generations of Pacific Islanders came to the United States for higher education (Xenos, et al., 1987). This trend will change the socioeconomic status of Pacific Islander immigrants living in the United States in the future.

Asian American Population Projections

Figure 18-3 shows the projected number of Asian Americans. By 2030, Vietnamese and Filipinos will become the largest Asian American minority groups, followed by Koreans and Chinese, unless significant changes in immigration laws take place (Xenos,

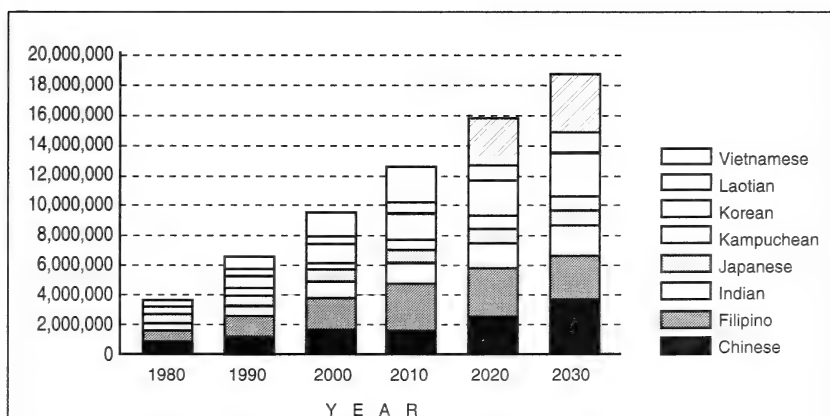


Figure 18-3. Projected Asian American Populations in the United States

Source: Bouvier & Agresta, 1987

et al., 1987). Japanese, once the largest Asian American group, will become a minority Asian American group due to small numbers of Japanese immigrants in recent years. The number of Pacific Islander immigrants is expected to grow as the Islanders seek higher standards of living in the United States (Xenos, et al., 1987).

The implications for a large influx of immigrants and geographical clustering of the immigrants are twofold: (1) the pressure to assimilate to the U.S. culture is less and (2) immigrants can better maintain their culture and drinking habits. Consequently they have less exposure to the U.S. mainstream culture. This is truer for Chinese Americans who were born, raised, and work in Chinatown San Francisco, for example, than for Chinese Americans who live in suburbs and work in organizations where very few Chinese Americans work.

Before comparing the drinking practices and alcohol-related problems of Asian Americans and the U.S. population, the case for genetic susceptibility to alcohol among the Asian population is reviewed. In particular, the review focuses on our knowledge of the flushing response, which drew considerable attention in recent years for its potential effects to prevent heavy drinking.

Genetic Susceptibility to Alcohol

There are two major enzymes to metabolize ethanol: alcohol dehydrogenase (ADH) and aldehyde dehydrogenase (ALDH2). The inactive form of mitochondrial ALDH2 isozyme is found among Asian populations (Suddendorf, 1989) and is associated with flushing reactions. Flushing reactions include facial flushing, nausea, headache, rush, itchiness, dizziness, drowsiness, anxiousness, perspiration, rapid heartbeat, weakness, and flushing elsewhere on the body; facial flushing is the most common reaction (Clark, 1988). These unpleasant reactions have been thought to deter individuals from heavy drinking and to explain low alcohol consumption among Asians. A study of facial flushing among Japanese in Japan and Japanese Americans in Oahu, Hawaii and Santa Clara, California, showed that respondents who reported flushing always after ingestion of alcohol were less likely to be heavy drinkers than those who did not. However, among individuals who reported facial flushing, the proportion

of heavy drinkers was higher in Japan than in Japanese Americans in Hawaii or Santa Clara (NIAAA and JNIA 1991), suggesting the importance of cultural factors in alcohol consumption. In a culture where pressure to drink heavily is high, being a flusher does not seem to prevent individuals from heavy alcohol consumption.

Harada, et al.(1982) reported that individuals with the inactive ALDH2 isozyme were substantially underrepresented in alcoholics compared with their nonalcoholic controls. Among alcoholics less than 3% had the inactive ALDH2 isozyme, compared with 41% of nonalcoholic controls. Goedde, et al. found great variation in the prevalence of the inactive ALDH2 isozyme among Asians (range: 8%–50%) and Native Americans (range: 4%–43%) (Goedde, et al. 1985). Even among Chinese, the prevalence varied from a low of 29.7% among Mongolians to a high of 50% among Han (Goedde, et al., 1984).

Genetic studies on the inactive ALDH2 isozyme are ongoing. Investigations at the National Institute on Alcoholism in Japan on the subtypes of inactive ALDH2 isozymes report that the distribution of subtypes of inactive ALDH2 isozymes between alcoholics and normal controls differs significantly, and some inactive ALDH2 isozymes may not be protective against alcoholism (Personal communication, Higuchi, 1993).

In recent years, the genetic aspect of alcoholism has received considerable attention. However, this emphasis may undermine the importance of social factors in drinking. In Islamic culture, where the use of alcohol is discouraged and access to alcohol is very limited, even if an individual is genetically prone to alcoholism, the risk of becoming alcoholic remains very low.

The Drinking Practices and Alcohol-Related Problems of Asian Americans and the United States Population

Drinking norms and drinking practices in the United States and Asian countries have changed over time. For instance, Klatsky,

et al. (1983) reported decreases in the percentages of abstainers and heavy drinkers (three drinks per day on average) among White, Black, and Oriental HMO enrollees in Northern California of both genders. Among Oriental men, the percentage of abstainers decreased from 36.8%, between 1964 and 1968, to 19.9%, between 1978 and 1980, while the percentage of White men abstaining decreased from 15.5% to 8.6%. Among Oriental women, the percentage of abstainers decreased from 58.0% to 39.7% during the same period; among White women it decreased from 25.0% to 12.2%. National drinking surveys also indicated changes in alcohol consumption patterns over the years (Hilton, 1988a; Hilton, 1988b).

In Japan, per capita alcohol consumption increased fourfold in the last four decades, and an increase in cirrhosis and esophageal cancer mortality rates among Japanese men followed (Parrish, et al., 1993). In Taiwan, per capita alcohol consumption increased from 9 liters in 1957 to 27 liters in 1984 (Yamamoto, et al. 1988). Due to changes in alcohol consumption patterns in many countries, cross-sectional drinking surveys should not be used to characterize ethnic groups' drinking practices. There is a need to monitor changes in drinking practices among newly arriving immigrants as well as those who are settled in the United States.

The Joint United States-Japan Alcohol Epidemiologic Project is the first survey to compare detailed drinking patterns among Japanese in Japan, Japanese Americans in Hawaii and Santa Clara, California, and Caucasians in Santa Clara (NIAAA and JNIA, 1991) (see table 1 for a detailed study design). Kitano and associates examined drinking practices among three study sites and Japanese Americans in Los Angeles from the previous study (Kitano, et al., 1988). They hypothesized that because Japanese immigrants in Hawaii were geographically clustered and physically closer to Japan than those in Santa Clara, the Japanese Americans in Hawaii would be less assimilated to the local culture than their Santa Clara counterparts, and their drinking habits would be more like those of the Japanese. In contrast, drinking patterns for Japanese Americans in Santa Clara would be similar to those among Caucasians. Their hypothesis was not supported.

They found that Japanese American men in Los Angeles had the highest percentage of heavy drinkers (35.8%), followed by Japanese men in Japan (32.4%), Japanese American men in Hawaii (29.0%), Caucasian men in Santa Clara (26.4%), and Japanese American men in Santa Clara (12.9%). Alcohol consumption for women was much lower than for men. Approximately 70% of Japanese women in Japan, Japanese American women in Hawaii or Santa Clara were either abstainers or infrequent drinkers. Only 40% of Japanese American women in Los Angeles or Caucasian women in Santa Clara abstained or drank infrequently (Kitano, et al., 1988).

Several factors made it difficult to study the effects of acculturation on drinking practices among Japanese Americans. First, California is a favorite destination for immigrants as well as for U.S. residents from other states. Comparing drinking patterns for Asian Americans with those for Caucasians in California may not elucidate the degree of acculturation among Asian Americans, because Caucasian samples may have moved to California in recent years.

Second, demographic factors, such as socioeconomic status, religious affiliations, and marital status differed considerably among Japanese Americans and Caucasians. This difference may account for the varying levels of alcohol consumption. Kitano, et al. (1988) found that over 60% of Japanese American men in Santa Clara reported an annual income of \$40,000 or more, compared with 45.2% for Caucasian men in Santa Clara and 19.8% for Japanese American men in Los Angeles.

Third, descendants of Japanese immigrants who came to the United States in the beginning of this century as farmers tend to have higher educational achievement and higher-paid jobs than their parents and their grandparents. Examining the differences in drinking practices across generations for the effects of acculturation may not be relevant due to the socioeconomic differences across generations.

Fourth, changes in drinking practices in Japan and in the United States make it difficult to interpret the observed differences in drinking patterns as a result of acculturation.

Fifth, the difference in the sampling frame may account for the discrepancy among study sites; the Los Angeles sample

included a much higher percentage of Issei (the first generation of Japanese Americans), including Japanese business men, who tended to be heavy drinkers. The authors did not clarify whether the removal of these Japanese men from the analysis would result in much lower alcohol consumption levels for the Los Angeles sample.

Although a study of Issei would give us an insight into the effects of acculturation on drinking practices, the number of Issei in the previous studies was too small to control for various factors affecting acculturation. Factors such as age at immigration, educational attainment, occupation, length of stay in the United States, and English proficiency would be important to consider in future research.

Differences in Drinking Practices among Asian Americans

In this section, a brief description of the differences in drinking practices among Asian Americans is presented, followed by a comparison of specific Asian American populations' drinking practices with practices in their native countries, where data were available.

In a northern California study during 1978 and 1980, Japanese American men had the lowest percentage of abstainers, followed by Filipino American men and Chinese American men (Klatsky, et al., 1983). In contrast, Filipino American women had the highest percentage of abstainers, followed by Chinese American women and Japanese American women. In the Los Angeles study mentioned earlier, drinking levels of Filipino American men were comparable to those for Japanese American men, while drinking levels for Filipino women were much lower than those for Japanese women (Lubben, et al., 1988; Chi, et al., 1989).

Chinese Americans

Chinese Americans came to the United States from different parts of Asia. In the northern California study, among those born outside mainland United States, the largest percentage of Chinese Americans was from mainland China (59.9%) (Klatsky and Arm-

strong, 1991). This was followed by those born in Hong Kong (17.2%) and in Taiwan (7.0%). Except in Taiwan, differences in drinking patterns in various regions of China are not well known.

Drinking surveys of Chinese Americans show that the drinking levels for both men and women were much lower than those for U.S. Whites and the other Asian groups (Kitano and Chi, 1986-87; Klatsky, et al., 1983; Klatsky and Armstrong, 1991). The Los Angeles survey also indicated that Chinese Americans reported a higher prevalence of abstention and a lower prevalence of heavy drinking though many liquor stores are owned by Chinese Americans (Chi, et al., 1989). Low cirrhosis mortality rates for Chinese Americans seem to support self-reported low alcohol consumption; the cirrhosis mortality rate for Chinese American men was 1.2/100,000 compared with 7.7/100,000 for U.S. White men between 1978 and 1980 (Yu and Liu, 1986-87). However, the sharp increases in alcohol consumption and alcoholism in Taiwan in the last 30 years (Yamamoto, et al., 1988) shows that drinking attitudes and alcohol consumption patterns have changed substantially. Even in a culture where the century-old Confucian idea of moderation in drinking has been a norm, the society is not free from a sharp increase in alcoholism.

Japanese Americans

Drinking attitudes, measured by how many drinks were appropriate for certain drinking situations such as "as a parent, spending time with small children, when with friends at home," among Japanese in Japan and Japanese Americans in Hawaii and Santa Clara were examined, and drinking attitudes among three groups differed significantly (Tsunoda, et al., 1992). Japanese generally reported much more permissive attitudes than their Japanese American counterparts even after drinking levels were controlled for (Parrish, et al., 1990). Even though drinking levels for Japanese women were lower than those for Japanese Americans, Japanese women showed equally permissive attitudes toward drinking (Parrish, et al., 1990). Kitano, et al., (1992) reported similar findings about drinking norms for gender- and age-specific groups, such as a young man about 21 years old; Japanese respondents reported more tolerant drinking norms for

men than Japanese Americans, independent of gender. Attitudes about drinking and drunkenness among the three sites also differed substantially, with the Japanese showing far more tolerant attitudes than the Japanese Americans sampled (NIAAA and JNIA, 1991). For example, 70% of Japanese men responded "yes" to "It does some people good to get drunk once in a while," compared with 30% of Japanese American men in Hawaii and 24% in Santa Clara. Japanese women, who reported the lowest level of alcohol consumption, showed equally permissive attitudes about heavy drinking, as did Japanese men. Since Caucasian samples were not asked these questions, it is not clear how Japanese Americans differ from U.S. Whites in Santa Clara. Considering the fact that the Japanese Americans' demographic profile include a high percentage of people born in the United States with high educational attainment, Japanese Americans' drinking norms may reflect mainstream U.S. drinking norms.

Korean Americans

Koreans have a reputation for heavy drinking (Yamamoto, et al., 1988). Koreans between the ages of 18 and 65 years in Korea were surveyed for a lifetime prevalence of alcohol abuse and dependence (3,134 respondents in Seoul, 1,966 respondents in rural areas; 51% of the sample were women) (Yamamoto, et al., 1988). The lifetime prevalence of alcohol abuse was higher among respondents in Seoul than in rural areas, whereas the prevalence of alcohol dependence was higher among respondents in rural areas than in Seoul. This suggests differences in drinking practices between Seoul and rural areas. The prevalence of alcohol abuse and alcohol dependence increased with age, and the prevalence for female respondents was less than 10% of the prevalence for male respondents. The difference in the prevalence between genders reflects the Korean drinking norm, openly discouraging women from drinking. Gender prevalence differences were greater in rural areas than in Seoul. When these data were compared with data from a United States sample from St. Louis and New Haven, the Koreans had a much higher prevalence of alcohol abuse and dependency than the United States sample using DMS III criteria (source not listed by Yamamoto, et al.).

The prevalence was 21.8% in Seoul, 22.4% in rural areas in Korea, 15.7% in St. Louis, and 11.5% in New Haven.

Kitano and Chi, (1986–87) show that Korean Americans have the highest percentage of abstainers among Asian American groups for both men and women in Los Angeles (Kitano and Chi, 1986–87). Yamamoto, et al. (1988) attribute this phenomenon to the selective immigration of Koreans to the United States. Koreans who immigrate to the United States have higher educational attainment and are more likely to be Christians (mostly Protestant) than Koreans in Korea. Over 50% of Korean American immigrants have Christian church affiliation compared with 12% for Koreans in Korea. Christian churches are a very important source of social support, and the churches discourage the use of alcohol. It is possible that underreporting of alcohol consumption among churchgoers in the survey may also account for low levels of self-reported alcohol consumption (Yamamoto, et al., 1988).

In the Los Angeles study, Korean American men who chose to drink were more likely to be heavy drinkers than the other Asian American men. Among respondents who reported drinking, 46.5% of Korean American men were heavy drinkers, compared with 34.7% of Japanese American men and 18.1% of Chinese American men (Chi, et al., 1988). This suggests the heterogeneity of Korean Americans, and the overall high percentage of abstainers does not indicate an absence of alcohol problems within this group.

Filipino Americans

Drinking practices of Filipinos in the Philippines are not well known. However, the Philippines are considered to have a strong Western influence on their culture due to a long history of colonization by Spain and the United States (Lubben, et al., 1988). Drinking patterns for Filipino men were closer in style to the West, i.e., heavier alcohol consumption, than to Asian Americans (Kitano and Chi, 1986–1987). In contrast, Filipino American women had a high percentage of abstainers, and their drinking patterns were similar to those for other Asian American women. However, respondents in this survey were not representative of Filipino Americans in the United States. Only 3% of the sample

was born in the United States, and over 90% had some college education; two-thirds were Catholic, and the majority reported attending weekly religious services (Lubben, et al., 1988).

Filipino Americans who were born in Hawaii were less likely to be abstainers than those who were born in the Philippines; the percentage of abstainers for Filipino Americans who were born in Hawaii was 15.1% compared with 39.6% for Filipino Americans born in the Philippines (Johnson, et al., 1987). Acculturation seems to play an important role in drinking practices. Much less is known about drinking practices for Filipino Americans than for those Japanese Americans or Chinese Americans in Hawaii and in the mainland United States. Further research is necessary to figure out drinking practices in different regions.

Indochinese Refugees

The incidence of substance abuse is increasing at alarming rates among Indochinese refugees (Yee and Thu, 1987). A study of 840 Indochinese refugees (90% Vietnamese) in Houston, Texas, and several cities in Louisiana showed that 40% of the respondents reported that they used some alcohol to diminish or handle sorrows or problems, and 5.8% used a lot of alcohol to do the same. The greater the refugees' worries, concerns, troubles, and depression, the higher the usage of alcohol and other drugs. Living in a more traditional, extended family household structure was associated with lesser use of alcohol and other drugs. Those with higher education had better English language abilities and were less likely to report depression (Yee and Thu, 1987). Their alcohol consumption patterns were not presented in the paper.

Discussion on Prevention Research

These data, although limited in scope, suggest that drinking practices among Asian Americans differ substantially. In studies to date, Japanese American men generally had the highest level of alcohol consumption, and Chinese Americans the lowest. Asian American women have tended to have much lower alcohol consumption than their male counterparts. Japanese American

women generally had the lowest abstention rates. The observed differences in alcohol consumption may in part reflect differences in the proportion of individuals born in the United States, as well as differences in socioeconomic status. The percentage of Japanese Americans born in the United States was generally over 70%; other Asian American groups had much lower percentages born in the United States, with the percentages varying greatly among studies. In the Los Angeles study, the percentage of the respondents born in the United States was 11.0% for Chinese men and 13.8% for Chinese women (Chi, et al., 1989).

In a study of the Health Maintenance Organization (HMO) enrollees in northern California, 39.9% of Chinese men and 41.8% of Chinese women were born in the United States (Klatsky and Armstrong, 1991). These HMO enrollees were more likely to be college graduates than were the Los Angeles samples. Asian Americans born in the United States were less likely to be abstainers than those born outside the United States (Klatsky, et al., 1983). A study in Hawaii also showed similar trends; Asian Americans (Chinese, Filipino, and Japanese) born in Hawaii had substantially lower rates of abstention than those born outside Hawaii (Johnson, et al., 1987). These studies suggest that place of birth is a better predictor of abstention rates than ethnicity.

Future research should examine the association between perception of alcohol abuse and self-reported drinking practices and drinking problems across populations. These differences may inflate or deflate self-reported alcohol consumption and drinking problems. Geographic differences in drinking practices within ethnic groups also need to be explored because drinking practices differ among regions (dry vs. wet regions). Previous studies were based on the West Coast because many Asian Americans reside there. However, drinking practices for Asian Indians, a large Asian American group, have never been studied.

Asia has a long and rich history of folk medicine and treatment, and each ethnic group has its own belief about illness and treatment. Hmong believe that a person's life is predetermined and medical care is worthless (Uba, 1992). These refugees, with little exposure to Western culture, are the most challenging for prevention research because little is known of their cultural

beliefs about alcohol abuse and alcoholism. Yet, they may be the highest risk group for alcohol abuse, as indicated by the study of refugees in Texas and Louisiana (Yee and Thu, 1987).

Research on these linguistically and culturally diverse populations requires good rapport between researchers and local communities. Bilingual researchers who are familiar with ethnic culture are invaluable for conducting research among Asian Americans and Pacific Islanders. These researchers can give feedback to the community about the study results and work with them on prevention.

There is a need to standardize the measurement of alcohol intake and to categorize drinking levels across studies for comparison. In the Los Angeles study (Kitano, et al., 1988), modified quantity and frequency were used. With this method, the percentage of heavy drinkers for Japanese American men in Oahu, Hawaii, was 29.0%, compared with the corresponding rate of 13% (heavier drinkers, ≥ 30 ml of ethanol/day) using the drinking categories adopted by the National Institute on Alcohol Abuse and Alcoholism. It is desirable to develop a drinking categorization that reflects the risk of alcohol-related morbidity and mortality. For example, an average of three drinks or more per day was associated with an increased risk of deaths due to cirrhosis of the liver (Parrish, et al., 1993).

Conclusion

This paper reviewed the history of immigration, demographic profile, and drinking practices among Asian Americans. Research about Asian American and Pacific Islander populations is limited, and the use of extant data is necessary to monitor the prevalence of alcohol abuse and alcoholism. Listed below are some areas in which more study and data are needed:

- immigration patterns,
- ethnic-specific cirrhosis mortality over time for larger ethnic groups, such as Chinese, Vietnamese, Koreans, and Indians,
- alcohol consumption, alcohol-related morbidity and mortality using HMO enrollee databases in areas of high concentrations of Asian Americans and Pacific Islanders, and

- surveys of Asian American and Pacific Islander clients at the bilingual counseling services to examine the magnitude of alcohol related problems.

The image of Asian Americans, once considered a model minority, is changing as Asian gang violence and illegal Chinese immigrants have become the front page news. As the percentage of U.S.-born Asian Americans increases, alcohol consumption and alcohol-related problems for these groups would be expected to increase. Furthermore, the number of Asian Americans has been growing rapidly, and they may become a target for liquor industry marketing just as African Americans have been targeted. The continuous monitoring of drinking practices is crucial for preventing further increases in alcohol abuse.

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Asian and Pacific Island Community Alcohol Prevention Research

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Introduction

For many years, the general public perceived Asian and Pacific Islanders as the minority group that has been successfully acculturated. Recently, however, even the popular literature indicates differing perspectives on this minority group. The lead article in *Time* magazine (Aug., 31, 1987) entitled, "Those Asian-American Whiz Kids," describes several Asian and Pacific Islanders who were very successful in school and related activities. The article drew the following conclusion: "The largely successful Asian-American experience is a challenging counterpoint to the charges that U.S. schools are now producing less educated mainstream students and failing to help underclass Blacks and Hispanics." Four months later, the *Los Angeles Times* published an article entitled, "Lost in L.A.," about a Vietnamese teenager who was involved in a Chinatown robbery attempt. Sang Nam Chinh, a 19-year-old refugee from Vietnam, was the lookout for a failed jewelry store robbery, resulting in one Los Angeles Police Department officer killed and another wounded. Chinh was also wounded and later went to prison. These two articles describe very different perspectives on the Asian and Pacific Islander communities. In reality, the Asian and Pacific Islander popula-

tions are both "successful" and "lost." It is crucial that alcohol researchers understand and appreciate this disparity.

The objectives of the paper include: (1) briefly review the available literature on the drinking patterns of Asian and Pacific Islanders, (2) explore a few important conceptual, methodological, and cultural issues related to community-based research in Asian and Pacific Islander communities, (3) describe some efforts at collaboration between Asian and Pacific Islander communities and alcohol prevention researchers, and (4) discuss specific examples of alcohol prevention challenges in the Asian and Pacific Islander communities.

Review of Literature on Drinking Patterns of Asian and Pacific Islanders

Few publications discuss the use of alcohol among Asian and Pacific Islanders. However, the National Institute on Alcoholism and Alcohol Abuse (NIAAA) funded research projects on alcohol use among Asian and Pacific Islanders and published the results. One monograph, "Alcohol Use Among U.S. Ethnic Minorities" (NIAAA, 1989), includes several articles dealing with alcohol use in Hawaii; alcohol use among Chinese, Japanese, Koreans, and Filipinos; and the "flushing" response to alcohol use. However, very little incidence and prevalence data were presented. This is due to the lack of local, state, or national data collected on Asian and Pacific Islanders living on the U.S. mainland. In general, data on drinking patterns among Pacific Islanders is even more difficult to obtain.

Although little data are available, the Republic of Palau Conference on Alcohol and Other Drugs in August 1991 identified the problem of alcohol consumption, especially among teenagers, as a serious problem (Polloi, Anthony. Personal Communication, August 1991). Hanipale and Whitney (In process) reported that alcohol consumption in American Samoa was about 22 gallons (of unspecified alcoholic beverage) per capita and on the increase.

Zane and Sasao found in reviewing the research literature that Asian and Pacific Islanders in general reported to have used

alcohol and other drugs (cigarettes and marijuana) at lower rates than African Americans, Hispanics, and Whites (Zane, et al., in process). They also identified a study indicating that alcohol drinking patterns among young Asian and Pacific Islander males were similar to those found for a national sample of young adult males (Cahalan and Cisin, 1976). Further, Cahalan and Cisin found that certain Asian and Pacific Islander groups had a high proportion of heavy drinkers. The heaviest drinkers were the Japanese subjects (25.4%), and Filipino subjects (19.6%), followed by the Koreans (14.6%) and Chinese (10.4%).

A Canadian study (Legge and Sherlock, 1991) found that highway traffic violations for driving while intoxicated were very low for Canadian Chinese (3 in 50,000 cases). However, a focus group of Sikh (Indo-Pakistani), who would be considered Asian and Pacific Islanders if they were in the U.S., estimated that 25% of males have alcohol problems.

Kim provides a useful literature review of various cultural constructs and discusses their relevance to Asian and Pacific Islanders (Kim, 1992). Kim examined several concepts regarding culture. He attempted to show how Asian and Pacific Islander alcohol use may be related to cultural issues. He also discussed culturally competent services and their importance in breaking the cultural barriers to seeking help.

Sue, et al. (1979) found that permissive attitudes associated with greater acculturation were related to heavier alcohol consumption. These important findings indicated that in alcohol consumption, Asian and Pacific Islanders use had been *underestimated*. Chi indicated that differences among Asian and Pacific Islanders in their alcohol consumption can be attributed to cultural patterns brought to the U.S. by their ancestors (Chi, et al., 1988, 1989).

Conceptual, Methodological, and Cultural Issues

Conceptual Issues

In discussing conceptual issues in conducting community research, it is important to consider how the term "community"

is defined. Although Asian and Pacific Islanders tend to be concentrated in urban areas, there are substantial, and growing, enclaves of Asian and Pacific Islanders living in rural communities on the U.S. Mainland, Hawaii, and the Pacific Islands.

Communities are often thought of as a geographical area with specific populations. Most of the Asian and Pacific Island population does not necessarily live in "Chinatown," "Little Tokyo," "Koreatown," "Little Saigon," or "Manilatown." Rather, the populations tend to be scattered across urban and rural areas. Care must be taken to accurately identify the Asian and Pacific Island population that is being defined as the "community." For example, there may be an Asian and Pacific Island group identified as a Chinese population. This Chinese population, however, could be Chinese from the People's Republic of China, Taiwan, Hong Kong, or "ethnic Chinese" from Vietnam, Mexico, Canada, or many other parts of the world. It is also not uncommon for Chinese enclaves (e.g., "Chinatowns") to be composed of individuals who speak various Chinese dialects, as well as ethnic Chinese, who may speak Vietnamese or other languages.

Methodological Issues

Two major methodological issues of concern to research on alcohol research among Asian and Pacific Islanders include language abilities and literacy and ethnic bias.

Language Abilities and Literacy: Researchers should be aware that the Western concepts of scientific method and research are not necessarily understood by everyone, especially new immigrant populations with little formal education. Many Asian and Pacific Island populations do not have much formal education, and may not be literate in their own language, much less English. Written communication will be difficult with some Asian and Pacific Island groups. Oral interviews and ethnographic approaches may be preferable sometimes.

Ethnic Bias: Westermeyer's *Ethnic Bias* (1989) makes the point that the U.S. Census Bureau data has ethnic and racial biases. For example, many ethnic minorities are not counted. Reasons for this undercount include the reluctance of many of these

groups to reveal themselves to government authorities for fear of legal difficulties and other adverse consequences. This reluctance applies to many Asian and Pacific Island groups, especially those that are recently naturalized citizens, refugees, or immigrants. In addition, many Southeast Asians moved from one location to another, trying to rejoin relatives scattered across the United States.

Another ethnic bias results from the sampling procedures used. For example, institutional records, such as hospitals and other public facilities, which are used as a data source, often do not accurately identify Asian and Pacific Islanders, particularly regarding their specific subgroup identification.

Ethnic and racial bias may also exist in data analysis and interpretation. Many surveillance data, national surveys, and other epidemiological studies normally do not include specific Asian and Pacific Islander subgroups. Putting all Asian and Pacific Islanders into the general category of "Asian" or "other" makes the data difficult to analyze and interpret. In addition, interpreting data requires a certain level of "cultural competence" and a thorough understanding of cause and effect relationships in diverse cultural groups. Because of the small number of the studies on Asian and Pacific Islander alcohol and other drug use and abuse, researchers must carefully interpret their findings, especially when generalizing findings to subgroups within the Asian and Pacific Islander populations.

According to Zane and Sasao (In process), the apparent low levels of alcoholism among Asian and Pacific Islanders were usually attributed to physiological reactions to alcohol and symptoms of discomfort. Some studies regarding the higher sensitivity of Asian and Pacific Islanders to alcohol have shown that cultural and environmental factors need to be examined along with the biomedical factors. Further, none of these research findings are based on a comprehensive study of all of the major Asian and Pacific Islander subgroups. Finally, the cultural appropriateness of the research instruments may not have been sufficiently considered, and an assumption may have been made that pharmacological research is "context-free."

Research on alcohol and other drug issues regarding Asian and Pacific Island populations typically uses limited sample pop-

ulations of university students or individuals in AOD treatment programs (Zane and Sasao, In process). The existing research does not generally include sample broad segments of the Asian and Pacific Island populations in a random sample. Two exceptions are the California statewide alcohol needs assessments by Special Services for Groups (1991), and the California statewide drug abuse needs assessments by Sasao (1991). These studies are discussed below.

Cultural Issues

Cultural issues are important factors in conducting Asian and Pacific Island research. Research needs to be conducted in a culturally competent manner that will be "good science" and will ultimately help empower the Asian and Pacific Island populations.

The Special Services for Groups study revealed that cultural issues affect drinking patterns in the various Asian and Pacific Island communities. One part of this study described how six different Asian and Pacific Islander groups were categorized based on their responses to the question, "Why do you drink?" The categories were "Social/peer Influence," "Escapist" (an attempt to rid themselves of unpleasant feelings, e.g., depression), and "Self-Actualizing." This study showed that subgroups drink for differing reasons. For example, Southeast Asians gave Social/Peer Influence as their reason for drinking more often than any other subgroup. In contrast, Filipinos identified with this category least. Filipinos and Koreans chose the Escapist category most often. In contrast, the Japanese chose the Self-Actualizing category most often. The Chinese subjects chose this response least often.

An epidemiological survey of alcohol use among Chinese, Japanese, Whites, and Asian-Whites of mixed parentage in Hawaii showed that both biological and cultural issues impact drinking patterns (Wilson, et al., 1978). Whites tended to drink more and flush (reddening of the face and other physical reactions to alcohol) less than Chinese or Japanese. The Chinese and Japanese did not differ from each other in drinking levels or flushing patterns. People of Asian-White mixed ancestry had a

mean alcohol consumption level close to the White subjects, but Asian-Whites had a greater tendency to flush than did the White subjects. These results showed that biological and cultural variables such as marital assimilation influence alcohol consumption (Zane and Sasao, In process).

Asian and Pacific Islanders have commonalities and differences in the way they perceive alcohol consumption versus other drugs. In a study of Vietnamese in Houston, Texas, and Louisiana, approximately 45% of the sample of 840 refugees reported problems with alcohol and/or tobacco use (Yee, et al., 1987). However, other drug use was not suggested as a problem. These Vietnamese refugees said that alcohol and smoking were an acceptable way of dealing with stress and other personal problems.

The Hanipale and Whitney study of drinking patterns among American Samoans describes the impact of the Samoan culture on their drinking patterns (Hanipale and Whitney, In process). The authors say that consuming alcohol was primarily a male activity in a society where females consumed alcohol only on special occasions. Young men in American Samoa drank in a social group. This was typically done away from the village, in a remote area where they did not disturb others. They gathered in small groups and their alcohol consumption tended to go through an informal ritual, beginning with a phase of informal banter and getting acquainted. These young men, typically between the ages of 14 and 25, then continued drinking into the next phase of the social interaction, labeled "daring entertainment," where the banter included more joking and teasing among themselves. This phase also included singing, with individuals providing entertainment, and tended to be noisier and more boisterous than the initial phase. This tone is in contrast to the strict, quiet demeanor that men of their age had to show in their villages where the elders and chiefs have higher status and the young men must work hard, do their duty, and wait until they are senior enough in the village to have more prerogatives.

As the alcohol consumption continued, typically without any food, the social interaction took on a "philosophical intimacy," where group members began to talk about more serious matters,

e.g., how they personally felt about their lives, problems in their family, and romantic relationships. When this "intimate" atmosphere in the group remained, the group would end with everyone going home on good terms. However, when some members of the group became angry, the interaction deteriorated into the final phase, which was the "breakup" of the group. This normally occurred when two or more individuals had an exchange of angry words and the group ended with bad feelings and/or physical fights, sometimes resulting in physical injury.

Older men drank in their own homes, served by their wives. They were waited on by the women of the family, provided food, and whatever they wanted while they were drinking. However, these men sometimes beat their spouses and children while drinking. It is estimated that as many as 30% of Samoan men have a drinking problem.

The drinking patterns in American Samoa are different from the United States. There are also differences in treatment approaches. For example, there is a Samoan equivalent to 12-Step groups. However, these self-help groups are not very similar to "AA" groups in the United States mainland. While they are self-help groups, there is virtually no confidentiality, since in American Samoa, everyone knows each other. The older men in these groups have higher status and typically do not self-disclose any personal failings, e.g., guilt. Younger men never confront their elders in the group. These groups tend to be focused on group activities and the welfare of the group, versus dwelling on personal feelings, problems, and self-disclosure.

Samoans interpret personal responsibility for their drinking behavior differently from other cultural groups. When a Samoan man gets drunk, it is considered a temporary example of bad judgement and a mistake. It is not considered a long-term, life-long personal problem, as it is generally considered by the usual United States mainland interpretation. When a Samoan man gets drunk and causes a problem, he will perform a ritualized apology to all of those whom he has offended. Under normal circumstances, the offending man will be forgiven and the slate will be wiped clean. If a particular individual continues to create problems, then he will be brought before the chiefs and the elders

of the village. The man and his family will be told what they must do to solve the problem. This process is obviously much different from the patterns of alcohol abuse and recovery in mainstream America.

Finally, Samoan men, according to Hanipale and Whitney, drink because they want "to feel strong," and to overcome their sense of powerlessness. Samoan society has undergone dramatic changes because of westernization, where the traditional roles and status of the chiefs have been eroded by Western culture, "cash economy," and the American-style educational systems. These changes detract from traditional culture and family practices.

The Hanipale and Whitney study points out the need to consider cultural factors in research, including developing culturally appropriate instruments and design. Each of the Asian and Pacific Island groups have different drinking patterns and reasons for drinking. Thus, prevention and treatment programs must identify these factors accurately in designing culturally competent services.

Collaboration Between Asian and Pacific Island Communities and Alcohol Researchers

There have been isolated instances in the past when Asian and Pacific Islander groups were not involved in planning and implementing research projects. As a result, this affected the availability of subjects and created a basic lack of cooperation from individuals and organizations that could have provided assistance. This process also detracted from the research findings. As a result, the contribution of data to the Asian and Pacific Islander communities was diminished.

The basic ethics involved in conducting good research are the same as with any community. This includes respecting the dignity of the subjects, the human subject's research protection, and the potential benefit to the population being researched. The ethical considerations and the emphasis on human dignity are

basic requirements for any research project. Development of a good research project will support subject empowerment. The idea of empowerment as described by Rappaport (1987) offers a helpful series of steps in developing community empowerment, resulting in getting the "buy-in" of those who should be actively participating and benefiting from the project. The key is to share decision-making power with community members.

To have access to a research population, the researcher must engender trust, credibility, and confidence. Researchers are usually from university settings, and some researchers have not been culturally sensitive, or have not adequately contributed back to the communities they used for subjects. Part of developing the necessary cooperation is to have a reasonable way of "giving back" to the community. Contributing something to the community can take many forms, for example, providing a personal briefing on the results of the research and offering technical assistance to community-based organizations. In addition, providing stipends or compensation for the time that the subjects give to participate in the research project is often very helpful. This is particularly true where the subjects are low-income, and many Asian and Pacific Islanders are low-income.

The California Statewide Alcohol Needs Assessment (Special Services for Groups, Inc., 1991) study demonstrates the efficacy of community involvement in a research project. The project was characterized by community participation in the design and the conduct of the research. The study emphasized the importance of studying as many Asian and Pacific Islander subgroups as possible throughout the state by involving individuals in a great many focus groups. Also, the tentative results of the study were shared with the community groups that had participated in the research, before the research findings were formally distributed. As a result, Asian and Pacific Islander groups felt that the study was relevant and helpful.

An appropriate method of bridging cultural, socioeconomic, educational, and language differences must be found. One method of bridging some of these differences is to make an arrangement with an indigenous Asian and Pacific Island community-based organization to assist in the sampling strategy.

Organizations such as the National Asian Pacific American Families Against Substance Abuse, Inc.; Asian Pacific Planning Council (Los Angeles), and the Pacific Island Substance Abuse Council (Guam) can assist in identifying community-based agencies that may be able to facilitate entree and create working relationships with Asian and Pacific Island communities.

Asian and Pacific Island populations are anxious to have good AOD-related research performed. Most communities would be willing to cooperate with researchers if their concerns were addressed. Researchers must, therefore, treat Asian and Pacific Island populations with dignity and sensitivity while helping them in solving their alcohol problems.

In "Problems in Pacific/Asian American Community Research," Yu (1982) outlined a number of problems she observed in doing research among Asian and Pacific Islanders. Research activities in ethnic communities sometimes became complicated by internal community politics. For example, a variety of agendas were acted out within the community, by individuals, each representing themselves as the true spokesperson of the community. Questions often arose about who should do the research, the theoretical presuppositions, the demand for bias-free methods, the need for research to be relevant to policy, community accountability, and theoretical interpretations. Yu offered the following recommendations for improving the relationship between the community and researchers:

1. Social researchers should work closely with the communities they plan to study to make sure that community groups have their perspectives heard and included.
2. Researchers should not be coerced into conducting research without the appropriate procedures and scientific rigor.
3. Community leaders need to understand the role that Asian and Pacific Islander researchers must play, i.e., both the social scientists as well as members of the Asian and Pacific Islander communities.
4. All parties should appreciate the roles that each community member plays and that there may be shared values in advocating for Asian and Pacific Islander community needs, but the

methods by which individuals choose to express their values may be different.

5. Community members should remember that research findings may not always be tangible and immediately applicable to solving existing human service problems.
6. Ethnic researchers have an obligation to assist communities in improving human services within those communities.

The above recommendations illustrate the need for clear communication between researchers, usually academicians, and community representatives. Often, differences in views on research can be resolved so that the research projects can be implemented. However, there may be a few situations where impasses occur and researchers have to respect the wishes of the potential research subjects and look elsewhere for volunteers. Understanding the role of research is very important, but, ultimately, empowering the community is the best way to assure a successful research project.

Research priorities for Asian and Pacific Islanders have been identified in several different forums. These include the 1991 California Statewide Alcohol and Drug Abuse Forum Report, the Proceedings of the Third NAPAFAASA National Conference, 1991, and the policy paper by NAPAFAASA to the Office of National Drug Control Policy (September 1991).

Finally, some university researchers have difficulty establishing rapport with potential subjects. University researchers generally have not been active and visible in community affairs where their support and participation are desired. Too often, academicians appear interested in community affairs only when they want assistance with their research projects. Technology transfer is not always a high priority for academicians, whereas it is a very high priority for community-based agencies. On the other hand, Chen, et al. (1992) have researched methods of public health education with Southeast Asians in the Midwest. Their research indicates that culturally competent techniques implemented by appropriate personnel with the necessary background, training, and experience can achieve effective health education and research results.

One example of a joint community- and university-based study was the NIMH-funded Nisei History Project, which was performed by the University of California, Los Angeles, with the collaboration of the Japanese American Citizens' League (a national civil rights organization). This collaborative partnership made the research possible and allowed access to many subjects in the Japanese American population throughout the United States, as well as identifying experts regarding Japanese American history and behavioral sciences.

NIMH also funded a National Asian American Mental Health Research Center at UCLA. This is currently the only national research center (on any type of public health issue) for Asian and Pacific Islanders. As an ethnically focused research enterprise with strong community ties, it has excellent access to Asian and Pacific Island communities, helps in empowering communities, and promotes technology transfer.

The NAPAFASA Programs of National Significance Project, funded by the Center for Substance Abuse Prevention, is an example of how community-based organizations can assist in a national demonstration project. This demonstration project was to identify, describe, and collect modest program evaluation data on existing substance abuse prevention programs focused on Asian and Pacific Island youth. The project identified eighteen community-based Asian and Pacific Island organizations on the U.S. mainland, Hawaii, and the Pacific Islands. Because it was a community-based organization itself, NAPAFASA had access to these organizations, which were more than willing to assist in the development of effective youth prevention strategies and model building.

Research Challenges

Individual Challenges

On the individual level, Zane and Sasao (In process) concluded that alcohol use can best be explained by a combination of "reciprocating" forces, including physiological, cultural, and environmental forces. Cultural factors in alcohol use include social skills

deficits and knowledge of how social skills are acquired by Asian and Pacific Island immigrants. In addition, the impact of cognitive-behavioral and community education programs on primary prevention and early intervention, family cohesion, peer relationships, and environmental forces (e.g., poor housing, racism, and anti-Asian violence) are forces that affect alcohol use. Researchers must therefore consider cultural issues when doing research among Asian and Pacific Islanders.

Public Policy Challenges

There are research challenges at the community level as well. Studies are needed to assess the extent to which alcoholic beverages manufactured in Asia and Pacific Basin countries and sold in the U.S. contribute to the drinking problems among Asian and Pacific Islanders. Restaurants and retail stores with liquor licenses, operated by Asian and Pacific Islanders in the U.S., affect drinking patterns and family attitudes regarding alcohol. Many restaurants and stores sell alcohol in the Chinatown, Little Tokyo, and Koreatown areas of Los Angeles. In certain areas of Los Angeles, attempts are being made to reduce the number of retail liquor outlets operated by Asian and Pacific Island merchants (Nakano, 1993). The concentration of these retailers in South Central Los Angeles has increased tensions. However, constructive ways of easing tensions are being implemented. These efforts include helping Asian and Pacific Island merchants to convert to businesses that do not sell alcohol. Further research should be done on the impact of public policy regarding alcohol sales and consumption among Asian and Pacific Islanders.

Prevention/Intervention Challenges

Due to the lack of epidemiological and etiological data, ethnographic studies, cultural research, and evaluation studies, very limited knowledge of specific alcohol prevention/intervention issues is available. Nevertheless, the California alcohol needs assessment study (Special Services for Groups, 1991) shows that any prevention effort needs to include a study of the reasons specific subgroups choose to drink. Effective prevention strate-

gies can then be designed and implemented specifically for each subgroup. The design of these interventions must be very specific to each of the Asian and Pacific Islander subgroups. The interventions will also have to vary within the subgroups by gender, age group, levels of acculturation, and socio-economic class.

Barriers to effective human service interventions for Asian and Pacific Islander groups include stigma, shame, denial, lack of financial resources, and an understanding of Western-style human service prevention and treatment methodologies. In addition, getting two or more Asian and Pacific Islander subgroups to collaborate among themselves can be problematic. Many of these groups do not have a history of working together and understanding each other's problems. Very often, community leaders are concerned about political issues and their spheres of influence and are therefore not predisposed to collaborating with other leaders around human service problems. Furthermore, collaboration with researchers, particularly those who are considered outside the Asian and Pacific Islander communities, tend to get mixed reactions and, in some instances, very little response to collaborative overtures. Many populations that are not highly educated along Western lines will not understand Western style research concepts and methods, and therefore simply have difficulty relating to attempts at implementing the scientific method and the design of research projects. Researchers must develop culturally relevant techniques to overcome these barriers.

A long-term educational process is needed to improve communications between Asian and Pacific Islander communities and researchers. This long-term process must affect both the research community and the Asian and Pacific Islander communities. When the researchers are culturally competent Asian and Pacific Islanders, the educational process and communication among groups will tend to be easier. That is why more Asian and Pacific Islanders must be involved in doing research regarding their own communities. As stated earlier, "ownership" and "buy-in" to the research project make the whole process more effective. Trust is key in establishing a productive research relationship with Asian and Pacific Islander communities (other groups, too). However, to engender this trust, there must be

meaningful communication, i.e., through language, customs, mores, values, norms, and attitudes. Simply talking to community groups and research subjects in the language in which they are most comfortable (e.g., Hmong, Korean, Palauan, Micronesian, Marshallese, Samoan, Chamorro, and Vietnamese) is very important.

Finally, researchers must also conduct research in an ethical manner to create an atmosphere that lends itself to honesty and trust between the researchers and the subjects. Human subjects, and Asian and Pacific Islander communities, must be provided informed consent, and their civil and personal rights as research subjects must be strictly protected. Obviously, no research subjects should be injured or exploited, as in the syphilis studies done many years ago on African American subjects.

Conclusion

Relatively little is known about the alcohol and related issues among Asian and Pacific Islanders. This is unfortunate, because what is available in the literature indicates that there are interesting facets to discover in this population. What has already been learned and what may be learned in the future will hopefully benefit all groups in the diverse American fabric. More research is needed to be sure.

NIAAA can play a crucial role in advancing research among Asian and Pacific Islanders by holding conferences and providing technical assistance for researchers regarding Asian and Pacific Islanders issues; expanding the announcements of research opportunities that include a special focus on Asian and Pacific Islanders; helping Asian and Pacific Islanders in developing a comprehensive data collection system regarding alcohol issues, and developing a partnership between alcohol researchers and prevention and treatment service providers to assure technology transfer.

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Issues in Alcohol Abuse Prevention Research in Asian American Communities: A Researcher/Community Perspective

Davis Y. Ja

Introduction

My comments are divided into two sections: (1) a few comments on the papers presented on Asian and Pacific Islanders and (2) more extensive comments on the entire working group, my thoughts on this process and the discussions that have taken place over the last two days. I approach this discussion from the background of someone who teaches psychology, conducts research, and yet is very involved in my community. For the last 25 years, I have worked in nonprofit community-based organizations focusing on Asian American mental health, drug abuse, AIDS, housing and labor in Seattle, Boston, Oakland, and now San Francisco.

Discussions of Papers on Asian- American Communities

Some comments that Dr. Kuramoto made about Asian and Pacific Islanders not being counted or included in the public health

strategy, I find Asians most often listed under an "other" category. This is a significant issue and a dilemma for our communities; if you don't get counted, then you don't count. Similarly, significant problems within our diverse ethnic communities are ignored since the "data" in terms of the federal bureaucracy reflects only "others" and does not differentiate specific problems with the Chinese community or the Vietnamese or Filipino communities. When you examine much of the aggregate data available, whether it's the household survey or the high school seniors survey, "other" is always present and probably accounts for approximately 15 percent of our resources in total research dollars. But who and what is "other" and to what degree does that provide us with any information that is meaningful for our communities? Since "other" is that little grab bag that contains Asians and Native Americans and whoever else you can throw in, it isn't readily interpretable; it becomes meaningless for us or anyone else.

A second and crucial issue that Dr. Kuramoto suggested earlier is the fact that we have 32 different distinct groups, different languages, different values, different aspects, different beliefs, different traditions. You want to conduct research in a Vietnamese community? Well, the fact is the Vietnamese community could be ethnic Vietnamese or Vietnamese-Chinese. Vietnamese-Chinese are primarily the boat people. These two groups often don't get along, and may not speak to each other. Assuming you hire someone to work with you, whether it is in a service capacity or let's say in prevention, and they're Vietnamese-Chinese. Well, their message may not be heard by someone who is ethnic Vietnamese. It's a very complex issue.

I do want to address a few comments to the issue of "flushing" that has been brought up. I wholeheartedly agree that flushing has less of a bearing than social-cultural factors in terms of alcohol use and abuse. I think we've wasted a lot of federal dollars trying to understand the genetic factors underlying alcohol abuse, particularly with Asians, and trying to find the magic bullet that somehow indicates that it's a genetic predisposition that factors into alcohol use and abuse.

We also need to understand that the extended family is very important in our community. We also need to try to find ways

to incorporate extended families into prevention efforts. Furthermore, social skills development and alternative recreational activities are also important tools that we can use as prevention interventions. Perhaps a multiple-method, multi-level approach incorporating various aspects of family involvement, teaching social skills, and providing recreational activities may be a better approach. That is what we are trying to do in San Francisco.

I agree that AA does not work well with the Asian community, whether in Hawai'i or on the continent. It's not something that we have been able to incorporate in much of our current efforts.

Religion does have some bearing in the mainland as well, particularly with some groups like Koreans, where there is a large number of Korean Christian churches with extensive congregations. Often we work closely with Korean ministers to incorporate their concerns and input into our prevention activities.

I also feel that cultural sensitivity cannot be separated from issues related to race. Cultural sensitivity may provide some skills and abilities for those attempting intervention activities, but race per se is a critical factor that cannot be simply differentiated from cultural-sensitivity. I do feel strongly that, in general, clients are most comfortable interacting with persons of their ethnic background and that indigenous treatment modalities are preferred, particularly with those who are immigrants, refugees, or those that have strong cultural traditions.

Discussion of Working Group Presentations and Comments

Now I'd like to make some comments regarding the last several days' discussion, particularly since I'm the last speaker. There are advantages and disadvantages to being the last speaker. I've had the opportunity of hearing what everybody else has to say, but there is much that has already been stated that I wanted to indicate earlier, and many of you have stolen my thunder.

First, I want to indicate that this working group has been an interesting process. In many ways, this working group is a

microcosm of our ethnic reality in society. We are all researchers to some degree, but we have people of color and we have people who are White. It is interesting because, as we were discussing various issues during the previous presentations, the discussions began to get heated. When the discussions became heated, I felt like things were beginning to be put on the table regarding the issue of color and that we were beginning to really address some very important issues. But the process that we have here in this working group is very time-oriented, very linear-oriented, and it's not colored people's time. I know that Phyllis and everyone else has put much effort into this, and I'm not saying it's your issue; I'm saying it's the institute's issue.

It is just that when the discussion got hot, what I would have liked to have seen is for us to continue that dialogue and push through that, because that is how we get things done in the community. If you want to do research in our communities, you have to deal with us with that perspective, and that was missing.

That is partly what it takes to do research, particularly applied and community-based research, and I hope that NIAAA takes this seriously. I hope that this dialogue continues and goes beyond just scratching the surface, because we have to break through this. We do not want to walk away angrily. If you are angry, let us talk about it so that we can move beyond and come together in real terms rather than just dealing with superficial niceties.

Like I said, we are people of colors, we are from these various communities. Many of us are still a part of those communities. We might not live there, but we certainly work there. Janet Mitchell works at Harlem Hospital every day, Susie Rodriguez is down at East L.A., Bob Robinson is still in Philadelphia trying to deal with R.J. Reynolds—we are there, and we are not just feeling the pulse, because we are part of the pulse. I think that is really important.

It is not that easy. I could leave, and I have, but I have come back home because it is what I want to do. It is my roots; I am committed to that community, and that is really important.

And it's also very frustrating to stand here again saying the same things I have said repeatedly. We were here in 1980 speak-

ing to ADAMHA, saying the same things I'm saying to NIAAA today—the very same things. It was a research agenda then: what should we do to do research in the ethnic/racial community, how should we do it? Three weeks ago, Larry Brown and I were here speaking to NIDA, to the prevention research branch, about this issue, and here we are doing the same thing for NIAAA.

So where does all this go? The one thing I know is that the pessimistic side of me says that it's 1992 and it's an election year. There is a pattern—1980, 1984, and 1992. And then the optimistic side of me says, well, the demography has changed; it is inevitable, they can't ignore us any longer. The Asian context is here, our numbers are higher. Then I keep thinking back—here's the pessimism again—look at the African Americans. Their numbers are so much higher, and what have they gotten?

The other thing Dr. Howard mentioned, we were talking about rape and pillage, and I want to bring that analogy back again, because there hasn't been a whole lot of rape and pillage from NIAAA in the Asian community; I have to admit that. But that is because, as far as our village is concerned, we are a couple of tiny low-down little huts down there. We're not even worth raping or pillaging.

But the fact is, our numbers are growing and we're beginning to see some alcohol-related problems with the Samoans, Hawaiians, and Japanese. What does that mean? They are coming—rape and pillage time. Maybe I should just start calling folks and saying Japanese community or Hawaiian community, watch out. NIAAA is coming. Because how are you going to come into our communities to do research? There's a million ways in the naked city, folks, and I've seen many of them because I've been there, and here are a few typical examples.

- (1) I used to be the executive director of one of the biggest Asian nonprofit agencies doing substance abuse work in the United States. Someone will call me and say we have got a great proposal and we want to work in the Asian community. When I ask what is the proposal about, they say let's sit down and talk about it. And, oh, incidentally, it has been funded. So they want my population, it's been funded, they

have an impossible research design, and I tell them to get lost. Well, they go next door, down to the Asian social service center, and they talk to them and try to convince them, and they keep bouncing around until they find someone who is sympathetic because they need some dollars. They buy them off with some spare change and they get into that community. That is one way.

- (2) Here is a second way. Do people know what a Buffalo soldier is? Some people have heard of Buffalo soldiers? Buffalo soldiers were Black cavalrymen after the Civil War who went out and killed the Indians for the White men. Well, we have Buffalo soldiers in the Asian community, and some of them are Asian researchers. There are actually a substantial number of them. When you look at the research institutes, there are a disproportionate number of Asians. But you know, it is funny when you look at where they are from. Some of these Asians came from White suburbia, joined a White fraternity in college and were considered acceptable. They never called themselves Asians. If anything, they called themselves "Oriental," which in our context is like saying I'm a "Negro." Some of these researchers get fronted off to our community, but they may have absolutely no understanding of who we are and what we are. They have a different basis in reality. Their skin color may be Asian, but they're something else. Often, I would much rather have people like you coming into my community and working with me than those "Orientals," because they are the most dangerous. I can deal with you. But it is hard to deal with them.
- (3) Here is a third way. Some university type, sitting in some office on some campus somewhere, gets funded by some research institute for a design he dreamed up out of his own head, and he does his study at the university with a college student sample. Half those Asians who are sampled are from overseas. They are not representative of our population, and unfortunately, these academicians publish. The saddest thing is that what they publish becomes part of the foundation of science that I must use if I want to start doing research—. These research findings may be fraught with errors and

biases. Much of our research legacy in the 1950s, 1960s, and 1970s has been personality and cross-cultural research done by White researchers, often predicated on stereotypical notions that Asians are passive or self-abasing. There are many studies of this kind, and the worst thing about it is that these are some of the same people that sit on the Initial Review Groups (IRGs). So if and when I want to submit a grant application, it goes to that person.

The bottom line is resources to conduct research, and that means money. Who does it go to? You know, it's very interesting listening to Dr. Langton speak about where those 27 grant applications came from that were submitted in response to the RFP. Almost half those grants were from minority Principal Investigators, and that is good to hear. Ten out of those 27 grants were submitted from community organizations. Now, if we sent those 27 grants that you received for that RFP to your regular IRG, do you know where those grants would go? To academicians and Whites. But if you set up a special IRG, then maybe we might get somewhere.

This is not to say a special IRG would not understand good science. I think some points have been made about that earlier, because we can have good science as well. The difference is that our priority may not be tenure. This has been mentioned before; it might not be tenure, it might not be money, it might not be claim to fame. I'm not saying those things wouldn't be nice; I would love to have those things, too.

We are interested in good science, but we have another priority. There is another priority operating here, and that is the fact that there is a genuine problem in our communities where we live, and these problems are serious. They're hot, and we saw it happen in Los Angeles.

Sometimes I have a hard time going to sleep at night because I see many problems in my community. We all see kids dying, shooting at each other, drinking and using other drugs. It's a struggle to continue to maintain the programs that we have because, as Suzie said yesterday, shrinking dollars mean shrinking resources. You know, we are not even doing stopgap in our

communities, and when a researcher comes in and says I have a bag of money and I want to do this, I get angry because that is what we need just to be able to survive.

But we also need information. We need to know, so it's important for us to have research. We want information. But you know what is more important? It is more important for you to have the information, so when you talk about the Asian community, it's much, much more than just a model minority to you. We have to convince you that we have a problem. How do we do that? Well, it's back to research.

We want research because we know that knowledge is power and it's also a political tool. Knowledge and fact can be defined by whoever holds the research hand. We don't have to go very far to know that. Research has been used as a political issue for many, many years.

NIAAA moving over to NIH raises concerns regarding research rigor and worrying about the social science research agenda. However, NIH also had their recent series of problems, particularly with Dr. Gallo being accused of unfairly making the claim to discovering HIV, but then being exonerated. That reminds me of four policemen who just got exonerated in Simi Valley very recently, and the thing that strikes me is what if Gallo was African American? Do you think he would have gotten exonerated? He would be tarred and feathered.

Research is knowledge, knowledge is power, and power is money. Money is resources for our communities that we need because it may mean the difference between life and death.

NIAAA has spent much money on "flushing" because the model minority myth is that Asians do not have alcohol problems. I would like to ask two questions, one to some of the researchers around this table and one to NIAAA, and then I'll conclude.

There are White researchers here, and you probably are the cream of the crop, the most sensitive. Some of you do credible and excellent work with minority communities. Dr. Beauvais' work is very interesting to some of my students who would like to incorporate some of his ideas in their dissertations and bring them to the Asian community.

The question is, because you are the best, can you still listen and continue a dialogue? If you cannot do it, then can you imagine what is happening with all those people out there who are doing research in ethnic communities? They do not have the same sensitivities that you may have. But you are supposed to be the most sensitive, the most enlightened, and you have been there.

No one is asking you to leave the community. No one is saying hey, get out of the Native American community. No one is asking you to get out of the African American community. No one has said that yet, and I think no one will. But it is hard to listen sometimes because after you put your best effort into it, you put your best work into it, you still feel, hey, I don't get any thanks for it. But this is part of that process.

If you are defensive, it means you are listening. And if you are listening, that means you are reacting and you are reacting emotionally. According to prevention research, you can change, because that is what it takes. Listening is one crucial aspect. Emotional reactivity is another. We need both, and then you can move forward as long as we continue the dialogue. When you are defensive you are listening, you are reacting; you do not quite understand yet, but you are moving toward that understanding as long as we can continue the dialogue.

If you're bored, that means you're not even listening. That means on the continuum you are here—, but you are not there yet. We need to reach you. That is our prevention research. We need to reach you if you are bored and indifferent, because you are writing us off and you are saying these are a bunch of radical types, they do not make any sense and they are nobodies anyway. But we need a way to reach you because we want you to work with us as well. We want everyone to work with us.

Some people are defensive; some people are understanding, and they are beginning to question. They are saying yes, there are some points there, I want to talk to you. That is perfect. That is what we want. Talk to us. Let's have dialogue.

And there are some here who really understand already. You have been through this. You can nod your head, oh yes, sure, of course, because you have been confronted and you have really

thought about it and you have had a lot of interaction; or maybe it is because you are a woman or maybe it is because you are a lesbian or maybe it is because you are Jewish or you are Irish, but there is some empathy there because you have seen it within your own cultural frame. You understand that process and what we're telling you is familiar.

Now it's hard for you to hear this, I realize that, and sometimes it is very frustrating. What I just want to say is that I am frustrated too, because I have been saying this for a long time. My frustration is that we live a reality of day-to-day racism. We get hit by this every day.

So let me move to NIAAA, with my biggest question. What are you going to do about this? I am very glad to hear about the fact that you are rewriting the RFA. I have no problems with NIAAA. Where it has to end is in policy. Policy that will reach the IRGs, staffing, advisory committees, and administrative staff.

The real challenge for NIAAA are the three goals we stated yesterday. We want to achieve a better understanding of how to do intervention and pre-intervention research in ethnic/racial communities. We want to better understand how ethnic/racial communities are unique resources for effecting certain types of social and behavioral change. We want to understand the process of information transfer with respect to proven and promising prevention research strategies.

The answer to that is how well you take on issues that I and others have raised here in the past two days. That will answer whether or not NIAAA will achieve these goals.

Part V

Framing the Research Agenda

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Alcohol Prevention Research in Ethnic/Racial Communities: Framing the Research Agenda

Jan M. Howard

Introduction

The ultimate goal of the research task here is a constellation of four objectives: (1) to better understand how to facilitate and energize scientifically based intervention and preintervention research on alcohol-related problems in ethnic/racial communities, (2) to learn more about the process of technology transfer to and from ethnic/racial communities of "proven" and promising prevention strategies, (3) to better understand ethnic/racial communities as unique resources for effecting certain types of social and behavioral change, and (4) to further develop, operationalize, and examine the concept of "participatory research" as it applies to ethnic/racial communities.

In this context, the phrase *intervention research* refers to testing strategies believed to have the potential of preventing or reducing alcohol-related problems. The emphasis is on the prevention of problems rather than their treatment after the fact. However, the distinction between prevention and treatment may be blurred, since the detection and treatment of problems in their incipient or early stages can prevent the later onset of more severe

problems and reduce the probability of relapse. *Pre-intervention research* is directly relevant to the *development* of effective preventive interventions and techniques to measure their impact. Tasks include identifying appropriate target groups, risk factors, outcome variables, and channels for delivering the intervention, as well as selecting (or constructing) and pretesting necessary measuring instruments.

The concept of *technology transfer* refers to a bidirectional process by which strategies that were effective in other settings and populations are adopted (or adapted) for use in ethnic/racial communities; and where, reciprocally, strategies perfected in ethnic/racial communities are transferred to the community at large (e.g., coalitions against alcohol advertising that targets specific groups). From a research perspective, the notion of technology transfer also encompasses its antithesis—deliberate and nondeliberate recalcitrance in adopting the policies and programs of other communities.

The idea of ethnic/racial communities as *unique resources* for change suggests that these communities have their own cohesiveness, needs, vibrancy, flexibility, inflexibility, and sociocultural definitions of reality. To the extent that such communities are unique, they represent a challenge to the ingenuity of alcohol prevention researchers. Even where these communities are mere microcosms of the larger society, they are still relevant targets for intervention studies, offering opportunities to replicate tests of interventions that have proven to be effective elsewhere.

Participatory research is in some sense an abstraction or reification that is still being operationalized in terms of actual experience. As currently defined in the limited literature on the topic, participatory research means that members of the target population are full partners with investigators in research planning, implementation, evaluation, and dissemination (DeCambra, et al., 1992). Advocates of the participatory perspective in ethnic/racial-focused studies assume that it helps to assure validity of the findings, cultural sensitivity, and researcher accountability (DeCambra, et al., 1992). However, these assumptions should be subjected to their own tests of validity in the variety of settings in which participatory prevention studies are being conducted.

Although the concept may be ideologically attractive, in practice participatory research may have both negative and positive effects on the integrity of the scientific endeavor.

In framing a research agenda to address the questions of interest here, certain distinctions should be drawn between the various objectives. The first and fourth objectives (facilitating prevention studies and examining the concept of participatory research) essentially require *research on research*, because the research process is the central focus of investigation. In the second and third objectives (examining mechanisms of technology transfer and understanding ethnic/racial communities as unique resources for change), the research process per se is not the focus of study; but the research on research perspective may still be germane.

For example, in studying the transfer of prevention technologies to and from ethnic/racial communities, investigators might also be interested in whether and how communication of research findings influences the diffusion of prevention strategies. Stated in question form: To what extent is the diffusion, adoption, or rejection of particular preventive interventions based on a foundation of scientifically grounded research as opposed to other considerations? In studying ethnic/racial communities as instruments for social change, it may be relevant for investigators to consider how members of these communities view the pros and cons of prevention research—whether they regard such studies as potentially beneficial or detrimental to their own indigenous objectives.

Systematic Phases of Prevention Research

Several federal Institutes that sponsor and engage in health-related prevention research (including the National Cancer Institute (NCI), the National Heart, Lung, and Blood Institute (NHLBI) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA)) have developed models that define prevention research in terms of a systematic progression of research phases that reflect an internal logic (Greenwald and Cullen, 1985; Green-

wald and Caban, 1986; Greenwald, et al., 1987; National Heart, Lung, and Blood Institute, 1987; and Flay, 1986).²

This logic presumes that research should move in measured steps along a series of relevant continuums:

- from descriptive hypothesis-generating pilot studies to full-fledged methodologically sophisticated hypothesis-testing studies
- from smaller to larger samples of subjects
- from convenience samples to rigorously defined subject populations that permit more precise generalization of findings
- from greater to lesser control of experimental conditions (frequently referred to as moving from "efficacy" to "effectiveness" studies (Flay, 1986))
- from more artificial "laboratory" environments to real-world geographically defined communities
- from testing the effects of single prevention strategies (or first order interactions) to more complex studies of multiple strategies integrated into intervention systems
- from research-driven outcome studies to so-called "demonstration" projects that evaluate the capacity of various types of communities to implement prevention programs based on these outcome findings.

Implicit if not explicit in models of research phases is a precautionary interest in possible deleterious consequences of preventive interventions. This type of concern is more likely to be expressed in test situations that mirror medically oriented clinical trials where the proscription to "do no harm" has historical precedent. For example, preventive interventions in the cancer area frequently involve so-called chemopreventive agents (such as beta carotene) or dietary "prescriptions" that may have negative side effects. These kinds of interventions tend to be conceptualized as proxies for drugs. And, taking their cue from the phases model of the Food and Drug Administration (Flieger, 1990; Young, 1990), the NCI and NHLBI attempt to determine toxicity levels early in the testing process.

However, in areas of prevention research that focus on behavioral change strategies as their intervention approach, there is a

tendency to down play negative side effects, in spite of evidence showing that certain behavioral technologies may have significant deleterious consequences. For example, results from evaluations of education programs to prevent youth substance abuse suggest that they have the potential to stimulate "alcohol and drug experimentation, especially when they are implemented by instructors who do not have adequate motivation and training" (Moskowitz, 1989, p. 70). And under some circumstances, young adults who are informed of the effects of drinking on BAC levels will increase (rather than decrease) their consumption of alcoholic beverages (Myers, et al., 1991).

More important, perhaps, than these "boomerang" effects of particular prevention strategies are threats to the scientific integrity of the research process itself, threats to the implementation of research as well as its validity. Problems can occur along the entire sequence of research phases from hypothesis and methods development through various forms of data collection and utilization. We know these problems exist, but conceptualizing them as research foci in their own right is essentially virgin territory. Generally speaking, we have neglected to study the research process itself, whether or not ethnic/racial communities are the targets of the intervention/evaluation efforts. Illustrations of problems that merit study from other fields of prevention and treatment research are instructive.

In discussing minority focused health research, DeCambra and colleagues (1992) observe that "the community response to conventional research may involve either indirect resistance or direct sabotage" and that these reactions are "culturally appropriate forms of self-defense, representing an adaptive response to a perceived imposition." However, in other types of minority communities, sabotage of the research process may simply be a perceived form of self-help rather than a deliberate attempt to undermine research per se.

For example, it has been observed (Melton, et al., 1988) that some AIDS patients involved in clinical trials of azidothymidine (AZT) surreptitiously shared doses of their "therapy" to ensure that all participants had some access to the experimental drug regardless of their assignment to treatment or control (placebo)

conditions. Obviously, such violations of protocol compromise the methodological integrity of clinical trials and the validity of results. Thus, attempts have been made to involve AIDS patients and their representatives more fully in the research process (Howard and Barofsky, 1992), including the design of clinical trial protocols that simultaneously meet the needs of science and the AIDS community (Byar, et al., 1990).

A down side exists for minority and majority communities if they isolate themselves from validation of the effectiveness of preventive interventions. Choosing to implement an untested or poorly tested prevention strategy, or one that has proven to be ineffective, can result in financial costs that are not offset by beneficial outcomes, even in the absence of actual harm. And failure to achieve desired objectives can dissuade policy makers from implementing and testing alternative or amended strategies that show greater promise of success. However, these problems would not necessarily be of concern to investigators unless they become involved in the final phases of research sequences, when technology transfer occurs and *research* demonstration projects give way to *service* demonstrations (Howard, 1993).

Pertinent Review Criteria

Public and private organizations that support alcohol prevention research and demonstration/evaluation projects have the opportunity to hold investigators and program implementors accountable to the state of the art. Questions such as the following deserve consideration and are being considered by scientifically astute grant review committees in the prevention area:

- Does the proposed intervention for testing rest on firm theoretical foundations?
- Is it relevant to the proposed target population?
- Is there sufficient statistical power to appropriately test the intervention, or will the guiding question remain unanswered?
- Is there convincing evidence that relevant community organizations will support the research endeavor?

- Will they help protect the scientific integrity of the study against such sources of bias as self-selection of subjects, respondent attrition, and self-serving questionnaires?
- How generalizable will the results of such a study be?

These kinds of questions reflect the fact that the success of scientifically sophisticated community prevention research depends on an in-depth understanding of the target community by the investigators involved and a genuine commitment of support and participation from the community itself. Community action groups are unlikely to obtain research funding from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) unless the principal investigators have established track records in conducting similar studies. Review committees are not disposed to sell science short. Nor are they disposed to minimize the importance of community collaboration.

Basic Issues for Research

Beyond these issues of interest to scientifically oriented review groups is another set of fundamental questions seldom addressed by designers or reviewers of alcohol studies in ethnic/racial communities. These questions are concerned with overarching social, psychological, and political realities that have important implications for the content and conduct of research as well as technology transfer. At the moment, credible information bearing on these issues is sometimes so scant as to be virtually nonexistent. Studies in related areas (such as case histories of the civil rights movement) may be instructive, but they are more likely to be useful as sources of hypotheses than sources of extrapolations.

The discussion to follow briefly examines some questions and themes that merit extensive exploration at the interface of alcohol prevention research and social action in ethnic/racial communities. The proposed list of topics is not meant to be exhaustive, but it provides a menu of understudied or ignored issues relevant to the constellation of research objectives set forth above.

Indigenous Social Movements

Much of the impetus for preventive interventions in the alcohol area comes from formal and informal community-based organi-

zations, of which some (e.g., Mothers Against Drunk Driving) have achieved national visibility and influence (Hingson, 1993). Ethnic/racial communities have developed their own indigenous social movements and strategies to reduce alcohol-related problems. One example is provided by recent extensive campaigns against billboard advertising of alcoholic beverages in areas heavily populated by ethnic/racial groups (Wallack, et al., 1993; Girard, 1988). Several aspects of this movement merit study:

- motivation of participants
- operationalization of the concept of empowerment
- perceptions of deleterious consequences of billboard advertising by participants and nonparticipants in the movement
- outcomes of the social campaign with respect to the advertisements, drinking behaviors of persons in those communities, and other indices of social change.

Protective Social Institutions And Processes

Studies show that African American youth have lower rates of alcohol use and abuse than Whites or Hispanics, across various school grades and indices of use (Johnston, et al., 1992). Data for Hispanic youth suggest a close resemblance to data for Whites, with no consistent tendency for either group to show the higher or lower rate of use or abuse (Johnston, et al., 1992), except that over time Hispanic youth have consistently reported lower rates of binge drinking than Whites (Johnston, et al., 1992,). In later life, however, African Americans (especially males) are at excessively high risk for acute and chronic alcohol-related illnesses such as cirrhosis and cancer of the esophagus (National Institute on Alcohol Abuse and Alcoholism, 1990, p. 33). And data for Hispanics suggest relatively high rates of alcohol-related problems (Caetano, 1986) including drunk driving (as measured by arrests for driving under the influence)(Ross, et al., 1991) and mortality from motor vehicle accidents (Sutocky, et al., 1993). Hispanics may also have a relatively high death rate from cirrhosis (See Caetano in this volume; Caetano, 1986).

Whatever the age group being considered, Asian Americans have historically shown less frequent use and abuse of alcohol than non-Asians (National Institute on Alcohol Abuse and Alcoholism, 1990; Kim, et al., 1992). However, the literature suggests that the drinking behaviors of subgroups of Asians may be changing in response to the growing numbers and heterogeneity of Asian immigrants and their progressive assimilation into American value systems (National Institute on Alcohol Abuse and Alcoholism, 1991; Kim, et al., 1992).

Studies of Indian youth on reservations show a consistent tendency over time for them to use alcohol more heavily than non-Indian youth, as indicated by frequency of drunkenness and blackouts (Oetting and Beauvais, 1989). Moreover, adult Indians in the United States show high rates of cirrhosis, alcohol-related trauma, and fetal alcohol syndrome (National Institute on Alcohol Abuse and Alcoholism, 1990). Yet, there is clearly great diversity in drinking behavior across tribal groups and within a given tribe (National Institute on Alcohol Abuse and Alcoholism, 1990; Heath, 1989). Some tribes are mostly abstinent while others show high levels of alcohol use and abuse, suggesting great variability in factors that precipitate or protect against hazardous drinking.

Research on alcohol problems and prevention strategies among the population at large tends to emphasize risk factors and their control rather than protective mechanisms. This narrow perspective constrains opportunities for culturally relevant prevention research. Protective institutions and processes (such as family and religious practices) could be conceptualized as naturally occurring preventive strategies, which can lose their potency under certain conditions (such as maturation and changes in living environments).

For investigators who conduct prevention research in ethnic/racial communities, recognition of the potential importance of naturally occurring protective processes may be theoretically and pragmatically helpful. It could facilitate the identification of endemic (culturally entrenched) preventive behaviors that deserve outcome evaluation in their own right and as intervening catalysts for ensuring the success of investigator-initiated interventions. Moreover, researchers who view ethnic/racial commu-

nities as dynamic systems involving protective as well as hazardous processes may be better received by target populations who are "tired" of being negatively stereotyped.

Sociocultural Institutions As Agents Of Change

Alcohol prevention researchers have identified ethnic/racial institutions that have the potential of serving as facilitators and expeditors of social change. For example, the church, family, and trade unions have been mentioned as possible vehicles for preventive interventions in African American or Hispanic communities (Caetano, 1986; Herd, 1986; Corbett, et al., 1991; and Ames and Mora, 1988); and the tribal council has been identified as a critical institution for effecting change in American Indian communities, particularly where different environmental controls over the availability of alcohol are a proposed intervention (e.g., becoming legally "wet" with enforced constraints) (May, 1986; May 1989).

A few alcohol researchers are engaged in pre-intervention research in ethnic/racial communities that attempts to understand the role of the family, church, and other indigenous community organizations in preventing or fostering alcohol-related problems. In some situations, these institutions play multiple and conflicting roles. For example, family members may attempt to discourage deleterious drinking while simultaneously serving as prestigious models for risky behavior. Similarly, churches may try to discourage problem drinking while concurrently sponsoring festivities and social events that can encourage hazardous drinking.³ And indigenous organizations that work to reduce social problems in ethnic/racial communities may face conflicts of interest if they accept financial donations from segments of the alcohol industry (Maxwell and Jacobson, 1989).

Pre-intervention research may be less threatening and visible to a community than research that tests specific prevention or behavioral change strategies. However, it may be difficult to convince authorities in focal institutions that studies of their organizations have relevance to the ultimate task at hand. If

these institutions propose themselves for study, entry should be easier than if the impetus for research comes from the outside. It should also be recognized that methodologies for organizational analysis frequently involve in-depth observations of policy-making processes and in-depth interviews of decision makers. Because these techniques can appear invasive and intrusive (mirroring in some respects investigative reporting), researchers must proceed cautiously, regardless of their own ethnic backgrounds.

Pertinence Of Findings From Studies Of "Majority" Populations

The concepts of "cultural sensitivity" and "cultural competence" have alerted us to the need for caution in applying findings from studies of Caucasian and Anglo populations to other groups in American society. However, it should not be assumed that ethnic/racial communities will respond differently to preventive interventions than majority groups respond. Cultural sensitivity simply demands that "proven" strategies be re-tested or reevaluated before their generalizability can be assumed.

Among the preventive interventions that have shown effectiveness in reducing alcohol-related problems in the population at large (National Institute on Alcohol Abuse and Alcoholism, 1990; National Institute on Alcohol Abuse and Alcoholism, in press; and Hansen, 1993), a number of strategies are ready for testing (and perhaps adaptation) in ethnic/racial communities. These interventions include:

- controls on drunk driving such as random road blocks, license revocation, enhanced law enforcement, and server training
- constraints on the availability of alcohol
- increases in the price of alcoholic beverages from taxes and other mechanisms
- changes in group norms and enhanced peer resistance skills through school-based programs
- techniques of persuasion that combine the mass media and more personal forms of communication.

One nonintrusive research approach is to measure intervention effects on ethnic/racial groups through secondary analyses of existing data sets that contain such demographic identifiers as race, ethnicity, and socioeconomic status. The best studies for the task here might be those that oversampled ethnic/racial populations. Sometimes, ecological (aggregate) data might serve as a proxy for individual identifiers, but conclusions drawn from ecological comparisons can be misleading or fallacious.

The alternative to secondary analyses is to start fresh and test in ethnic/racial communities interventions that have shown promise in populations that are largely Caucasian or Anglo. This approach obviously requires access to such communities and appropriate support. Access need not necessarily depend on the receptivity of ethnic/racial-group "gatekeepers." For example, segments of the hospitality industry that serve alcoholic beverages to persons of color may actually be controlled and managed by Whites. Similarly, school districts that serve children who are primarily nonwhite may be controlled by persons who are primarily White; and law enforcement in ethnic/racial communities may be formally beyond the control of those communities. In most research situations, however, the ability to conduct an effective study ultimately depends on the cooperation of the subjects involved (whether they are patrons, pupils, drivers, employees, or telephone respondents).

As indicated above, promising prevention strategies may emanate from minority rather than majority communities and be reported to the public at large through the mass media. Examples include the campaigns against alcohol billboard advertising in African American and Hispanic communities (Wallack, et al., 1993), efforts to constrain rebuilding of alcohol outlets in South Central Los Angeles after the fires (Sonenshein, 1993), and the forthright attempt of the Alkali Lake Indian Band to reduce their alcohol problems (Alkali Lake Indian Band, 1985). These indigenous mobilizations have important prevention implications for majority as well as ethnic/racial communities. They should, therefore, be studied in their own right and in terms of their potential for and instances of technology transfer.

Validity Of Findings

Because alcohol use and abuse have moral and legal implications, answers to questions concerning alcohol-related behaviors are vulnerable to the influence of these moral/legal considerations. Self reports, which form the major source of epidemiologic data, are particularly susceptible to "social acceptability" distortions. But sensitivity to issues of privacy can distort other forms of data as well. For example, physicians may refrain from entering into patients' charts evidence of alcohol abuse; and these protective actions may be influenced by the race, ethnicity, and socioeconomic status of the patients involved.

Moreover, people who have been victimized by legal systems may be reluctant to voluntarily provide blood, urine, or breath samples for confirmatory analysis (Howard and Barofsky, 1992). And they may pressure administrative and legislative bodies against collecting data that allows linkages between stigmatized behaviors (such as alcohol abuse) and stigmatized demographic characteristics (Howard, et al., 1989).⁴

One proposed technique to increase the validity of self reports is to use interviewers indigenous to the target ethnic community. Experts have suggested to the author that the ethnic status of interviewers is most likely to influence ethnic/racial responses to politically sensitive questions. It remains to be determined whether questions about alcohol abuse and its prevention fall into the "political" category.

Clearly, this whole area of validity with respect to ethnic/racial-focused research merits investigation, because it bears on the credibility of conclusions drawn from such research. Related issues concern the representativeness of study populations. For example, it has been argued that ethnic/racial respondents who complete high school or who have telephones may be a more select subgroup of the population at risk for alcohol problems (or protected from them) than their Caucasian/Anglo counterparts. These types of concerns have prompted some investigators to focus on the identification of school dropouts and techniques of ensuring adequate follow-up. And grant review committees have been willing to approve home interviews as a means of expand-

ing samples of ethnic/racial subjects to include persons beyond the reach of telephones.

Perceptions Of Problems And Solutions

Ethnic/racial communities may have a special stake in the results of epidemiologic and intervention studies in the alcohol area because of problem prevalence, ethnic pride, fears of disempowerment, and the quest for self-determination and improvement. A wealth of evidence suggests that ethnic/racial groups are concerned about alcohol problems in their communities. Thus, for example, most American Indian tribes have elected to proscribe the sale of alcohol within reservation boundaries (May, 1989).

Yet, we have a paucity of systematic data regarding such issues as community definitions of alcohol problems, awareness of their prevalence, perceptions of their relative importance vis-a-vis other community problems and priorities, perceptions of problem etiology, preferred approaches to the reduction of alcohol problems, and how ethnic/racial populations and subpopulations interpret and "receive" strategies proven to be effective elsewhere.

Ethnographic data from an ongoing study of Hispanics suggest that interest in self-rule can take precedence over environmental solutions to alcohol problems when these solutions are imposed or implemented by outsiders. There are also reasons to believe that findings that suggest genetic causes of alcohol problems among ethnic/racial groups may be particularly suspect, necessitating investigator adherence to higher-standards of scientific proof and replication than are usually required.

Conclusion

The central integrating theme in this paper is the issue of *participatory research*; the idea deserves research attention by itself. Although the focus of this monograph is ethnic/racial communities, participatory research is germane to any community-based intervention study in which the success of the research endeavor depends on participation of community residents. Such participation may involve shared decision-making with respect to the

interventions to be tested, target populations, the experimental design, types of questions to be asked, selection criteria for project personnel, and management of the project.

Research on participatory research should focus on the following types of questions: To what extent is the participation of community members necessary to implement and complete the research project? Does participation threaten the scientific integrity of the study? And if so, how can that integrity be protected? Given community participation, is the concept of "investigator-initiated interventions" a realistic notion? Or are the interventions actually initiated and shaped by the community? Assuming the latter, to what extent is it possible to generalize research findings to other communities? Is participatory community research more akin to "*natural experiments*"⁵ than to traditional research in which the investigator controls the intervention to be tested? Do interventions implemented through participatory research have greater staying power after the study is completed than interventions prescribed solely by the investigators?

With specific reference to ethnic/racial communities, other questions of interest concern the degree to which cultural sensitivity and competence are necessary conditions for the success of the research endeavor and how these concepts are operationalized in practice. Additionally important are questions concerning the representativeness of ethnic/racial participation in community research projects. How can researchers ensure that the sharing/participatory process involves all relevant subgroups of the community and that all participants appreciate the precepts of science?

Studies of participatory research are likely to include qualitative (e.g., ethnographic) and quantitative methodologies to document the process of community participation and nonparticipation. Ideally, that process should involve a continuous exchange of ideas and a continuous interpretative dialogue between researchers and members of the community regarding intervention approaches, apparent successes and failures, and new hypotheses or "gut" feelings that may merit study in their own right.

Succinctly stated, there is a critical need for realistic systematic appraisals of factors that facilitate and factors that impede

state-of-the-science prevention research in ethnic/racial communities.

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End Notes

1. The scale used to measure acculturation has been described in detail by Caetano. Briefly, the scale was built with twelve items assessing daily use and ability to speak, read and write English and Spanish; preference for media in English or Span-

ish; ethnicity of the people respondents interacted with in their church, parties, and neighborhood now and when growing up, as well as questions about values thought to be characteristic of the Hispanic way of life.

2. The phases model developed by NIAAA is still being refined.
3. Recent awareness by churches of their possible contribution to risky drinking has prompted efforts to reduce social activities that involve alcohol and the amount of alcohol served.
4. There are reasons to believe that the physically disabled may differ from other stigmatized groups in this regard; that they may wish to have their substance abuse problems validated through enumeration to attract greater interest in their problem.
5. "Natural experiments" are defined by the author as "studies of naturally occurring preventive interventions and programs"—i.e., the interventions are outside the control of the investigator (Howard, 1993).

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